(8)

No 83-2136

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

STATE OF CONNECTICUT
DEPARTMENT OF INCOME MAINTENANCE,
Petitioner,

v.

MARGARET M. HECKLER, SECRETARY, AND THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Respondents.

On Writ Of Certiorari To
The United States Court of Appeals
For The Second Circuit

JOINT APPENDIX

REX E. LEE
Solicitor General
KENNETH S. GELLER
Deputy Solicitor General
KATHRYN A. OBERLY*
Assistant to the
Solicitor General
Department of Justice
Washington, D.C. 20530
(202) 633-2217
Attorneys for Respondents

CHARLES A MILLER*
MICHAEL A. ROTH
ROBIN J. ARMBRUSTER
COVINGTON & BURLING
1201 Pennsylvania Avenue,
N.W.
P.O. Box 7566
Washington, D.C. 20044
(202) 662-6000
Attorneys for Petitioner

PETITION FOR CERTIORARI FILED
JUNE 28, 1984
CERTIORARI GRANTED OCTOBER 29, 1984

**Counsel of Record*

PRESS OF BYRON S. ADAMS, WASHINGTON, D.C. (202) 347-8203

43
Sheets

TABLE OF CONTENTS

APPENDIX A

HEALTH CARE FINANCING ADMINISTRATION

BOSTON REGION:
CONNECTICUT, MAINE, MASSACHUSETTS,
NEW HAMPSHIRE, RHODE ISLAND, VERMONT

FM CONTROL NO. 3-8001

Review of Costs Claimed by the Connecticut Department of Income Maintenance for Services Provided to Title XIX Recipients Residing at Middletown Haven Rest Home Middletown, Connecticut

For the Period
January 1, 1977 Through September 30, 1979

May 1980

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION I
JOHN F. KENNEDY FEDERAL BUILDING
GOVERNMENT CENTER
BOSTON, MASSACHUSETTS 02203

MAY 8, 1980

HEALTH CARE FINANCING ADMINISTRATION
Medicaid

In reply refer to:
HCFA/MB/DM

Audit Control No. 38001

EDWARD W. MAHER, Commissioner
Department of Income Maintenance
110 Bartholomew Avenue
Hartford, Connecticut 06106

Dear Commissioner Maher:

Enclosed are two copies of our final report covering a "Review of Costs Claimed by the Department of Income Maintenance for Services Provided to Title XIX Recipients Residing at Middletown Haven Rest Home in Middletown, Connecticut." Your comments of April 18, 1980 on the draft report are also incorporated in this report.

With respect to the fiscal disallowance of $1,634,655 FFP for payments to Middletown during the period January 1, 1977 through September 30, 1979, a formal disallowance letter will be forthcoming through our Central Office. Similar disallowances for subsequent periods will also be processed, until we have been provided sufficient assurance that the situations identified in this report no longer exist. We would also appreciate being informed of all proposed corrective action, to minimize loss of any additional Federal funds.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), this report is available, upon request, to members of the press and general public to the extent that the information contained therein is not subject to exemptions in the Act, which the Department chooses to exercise. (See Section 5.71 of the Department's Public Information Regulation, dated August 1974, as revised).

If you have any further questions on this matter, do not hesitate to call me.

Sincerely yours,

ALFRED G. FUOROLI
Regional Medicaid Director
Medicaid Bureau

FM CONTROL NO. 3-8001

Review of Costs Claimed by the Connecticut Department of Income Maintenance for Services Provided to Title XIX Recipients Residing at Middletown Haven Rest Home Middletown, Connecticut

For the Period January 1, 1977 Through September 30, 1979

HEALTH CARE FINANCING ADMINISTRATION
MEDICAID BUREAU
REGION I
BOSTON, MASSACHUSETTS
MAY 1980

REVIEW TEAM MEMBERS

WILLIAM DOYLE, AUDITOR, TEAM LEADER

PAUL DUVAL, PROGRAM SPECIALIST—CONNECTICUT MEDICAID STATE REPRESENTATIVE

DR. LAWRENCE OSBORN, PSYCHIATRIST CONSULTANT ON LOAN FROM UNITED STATES PUBLIC HEALTH SERVICE

NANCY MCGILLVARY, PSYCHIATRIC NURSE, MASS. DMH RETAINED ON A CONSULTING BASIS

WALTER WILLOUGHBY, FINANCIAL MANAGEMENT SPECIALIST

DEBORAH CALLAHAN, FINANCIAL ASSISTANT

CAROL BERMAN, STUDENT TRAINEE

TABLE OF CONTENTS

Table of Contents (Continued)

INTRODUCTION

Background

Title 42 CFR 435.1009 defines an institution for mental disease (IMD) as "an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such." The Connecticut Department of Income Maintenance has elected through its approved State plan to exclude services to the mentally ill in IMD's as a covered service under the Medicaid program. Accordingly, payments provided for such services are not eligible for Federal Financial Participation.

There have been recent indications that the State of Connecticut has been discharging large numbers of mentally ill patients from State mental institutions into skilled nursing facilities (SNF's) and intermediate care facilities (ICF's). The first official evidence became available when reviews conducted by the Health Care Financing Administration's (HCFA) Regional Office of Health Standards and Quality Bureau identified an unusual patient mix in Lorraine Manor of Hartford, Connecticut. The Bureau's report stated that about 100 of the 220 or 45 percent of the patients residing in this skilled nursing facility were diagnosed as having a psychiatric illness at the time of their review in May 1979. These patients were almost all admitted from Fairfield Hills Hospital, a State-operated psychiatric hospital. On the basis of this report, the Regional Medicaid Director issued a letter to the Connecticut State agency on June 11, 1979, deferring reimbursement of Federal Financial Participation for payments made to Lorraine Manor on behalf of Title XIX recipients for the

quarter ended March 31, 1979. The grounds for this decision was the lack of assurance that the facility was not an institution for mental disease or possibly an institution for mental retardation.

Following the above action, meetings were held with State agency officials to discuss the issue raised at Lorraine Manor. State agency officials were told that there was evidence that the situation at Lorraine Manor was only one instance of a much larger state-wide problem which needed to be addressed. The Regional Medicaid Director asked that the State undertake an in-depth review of patient discharges from State mental institutions. On July 18, 1979, State officials from the Department of Income Maintenance, the Department of Mental Health (DMH), and the Governor's office, agreed to the following commitments:

1. That all further discharges from public institutions for the mentally ill into SNF's and ICF's would be discontinued until an acceptable discharge policy was put in place.
2. That all mentally ill patients in general care facilities would be reviewed by staff from DMH to assure appropriateness of placement and delivery of care to meet their special needs. Because of the fact that the number of such patients was deemed to be large and because the number of facilities involved were six or more, it was agreed that such reviews by DMH should begin at Lorraine Manor and continue apace throughout the other facilities as time and staff resources permitted.
3. That the Commissioner of DMH would make available a list of all mentally ill patients discharged from DMH facilities into SNF's and ICF's in the past three years.

Also, on August 6, 1979, DMH provided HCFA's Medicaid Bureau with a copy of their policy governing the discharge of mentally ill patients from DMH facilities into

SNF's. (Attachment A) On November 2, 1979, the Medicaid Bureau took exception to some of the elements included in this discharge policy. (Attachment B)

In order to discuss these differences more at length and to negotiate the remainder of the delivery of actions agreed upon at the meeting of July 18, 1979, a number of contacts and meetings were held with various State officials. As a result of these discussions, we were subsequently left with no assurance that the agreed upon actions discussed on July 18, 1979 would be taken.

With regards to the list of all mentally ill patients discharged from DMH facilities into SNF's and ICF's in the past three years which was not provided as agreed, we did obtain certain meaningful information included in the Commissioner of DMH's testimony before the Subcommittee on Nursing Homes of the Public Health Committee of the Connecticut General Assembly regarding nursing home utilization by his Department. As part of the testimony submitted for his appearance on October 24, 1979, a member of his staff made available to the Subcommittee the following information: during fiscal year 1978 (July 1, 1977—June 30, 1978) 851 patients were discharged from DMH facilities into nursing homes, the DMH facilities were identified, with the number of patients given by facility and the names of six nursing facilities were listed as receiving these patients: Lorraine Manor, East Hartford Convalescent Home, Meadows Convalescent Home, Middletown Haven Rest Home, Hillside Manor and Prospect Gardens. A comment is made in the Subcommittee document: "However, because of recent concern over their eligibility for Federal Medicaid reimbursement, the following nursing homes are no longer used for DMH discharges."

The Medicaid Bureau, analyzing its posture regarding this problem in Connecticut, considered the following facts. While it was subsequently found that Lorraine Manor was not in direct violation of Federal regulations as being

"primarily engaged" in the diagnosis and treatment of the mentally ill (51 percent rule), the large number (over 100) and the percentage (well over 40%) evidenced massive discharges of mentally ill patients in violation of the spirit, if not the intent of the regulations. In addition, other facilities might be exceeding the 51 percent rule and be in direct violation of Federal regulations based on the above-cited testimony given the Connecticut Subcommittee on Nursing Homes. It was decided that the Medicaid Bureau could not ignore this critical problem and that it would conduct reviews at other facilities. The initial facility selected for review was Middletown Haven Rest Home.

Scope of Review

The review of Middletown Haven Rest Home was initiated at the request of the Regional Medicaid Director and was made in accordance with the financial and compliance standards for governmental auditing. Our review of expenditures claimed for this facility covered the period January 1, 1977 through September 30, 1979, whereas, our review of patient records covered the period January 1, 1977 through December 18, 1979. The primary purpose of the review was to determine whether the facility is in fact an IMD as defined in 42 CFR 440.140(a)(2) and 42 CFR 435.1009(e) or an ICF as defined in the approved State plan.

In conducting this review, we researched applicable Federal laws, regulations, policy interpretations and State plan requirements in order to properly define an IMD. In addition, we obtained the services of a psychiatrist and psychiatric nurse to review patient records for the period January 1977 through December 18, 1979. Based on these reviews, we determined the percentage of mentally ill patients in relation to the total population of the facility. The facility's license and staffing procedures were also examined to determine the character of the institution. We

also reviewed Independent Professional Review reports at the State agency's Office of Medical Services and Medical Review Team Disability Determination Reports at the Middletown District Office.

We also reviewed Quarterly Statement of Expenditures to determine the payments made to Middletown Haven Rest Home for which Federal Financial Participation was claimed for the period January 1, 1977 through September 30, 1979. Additionally, we held discussions with the facility's owner, Administrator, and other staff members as well as with various State medical and financial personnel.

A nurse from the State agency acted as an observer during certain segments of our review of patient records at the facility.

RESULTS OF REVIEW

Our review showed that Middletown Haven Rest Home is an IMD which provides psychiatric services to individuals who are under and over 65 years of age. As a result, all of the amounts paid to this institution are not allowable for Federal Financial Participation as the State plan does not cover services to the mentally ill in IMD's (Attachment C). The unallowable expenditures amount to $3,269,310 (Federal share $1,634,655) and are identified in the following schedule:

Expenditures Claimed by the State Agency on Behalf of Medicaid Recipients Residing in Middletown Haven Rest Home

	All Recipients		Recipients Between 21 and 65 Years of Age	
Quarter Ending	Total Expenditures	Federal Share	Total Expenditures	Federal Share
3/31/77	$ -0-	$ -0-	$ -0-	$ -0-
6/30/77	91,169	45,584	39,534	19,766
9/30/77	114,817	57,409	66,232	33,116
12/31/77	175,841	87,520	115,787	57,894
3/31/78	163,758	81,879	113,660	56,830
6/30/78	221,262	110,631	161,805	80,902
9/30/78	281,382	140,691	201,337	100,669
12/31/78	690,954	345,477	500,989	250,405
3/31/79	529,244	264,622	370,443	105,221
6/30/79	527,792	263,896	365,700	182,850
9/30/79	473,891	236,946	338,789	169,395
	$3,269,310	$1,634,655	$2,274,276	$1,137,138

Although total expenditures have been deemed unallowable on the basis of State plan requirements, we cannot ignore the fact that they also include $2,274,276 (Federal share $1,137,138) that have been specifically precluded from Federal reimbursement because they apply to individuals between 21 and 65 years of age. Section 1905(a)(vi)(17)(B) of the Social Security Act specifically prohibits Federal Financial Participation for this age group and judging by the amounts included in the total claim it is evident that this Statute has not been considered in the computation of the State's claim.

The purpose of our review as previously stated was to determine whether in fact this facility was an IMD. In making this determination, it was essential to determine in accordance with Bureau Guidelines whether this facility is "primarily engaged" in the care and treatment of individu-

als with mental diseases and whether its "overall character" is that of an IMD within the meaning of the Statute. The detailed results of our determination are presented in the following sections.

Federal Regulations

Federal regulations define what constitutes an IMD. An IMD "means an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such." 42 CFR 435.1009(e). This definition of an IMD applies to an ICF as well as a SNF.

Medicaid Bureau Guidelines

Based on the above citations HEW has developed criteria to determine what constitutes "primarily engaged" and the "overall character" of a facility in order to arrive at a determination that a facility is indeed an IMD. The determination that a given facility is an IMD will be based on a cumulative weighing of the following eight factors:

1. That a facility is licensed as a mental institution,
2. That it advertises or holds itself out as a mental institution,
3. That more than 50% of the patients have a disability in mental functioning,
4. That it is used by mental hospitals for alternative care,
5. That patients who may have entered a mental hospital are accepted directly from the community,
6. That the facility is in proximity to a State Mental Institution (within a 25 mile radius),

7. That the age distribution is uncharacteristic of nursing home patients, and
8. That the basis of Medicaid eligibility for patients under 65 is due to a mental disability, exclusive of services in an institution for mental disease.

These criteria are contained in instructions issued by the Medical Services Administration (the predecessor organization to the Medicaid Bureau before reorganization into the Health Care Financing Administration in 1977) which are Field State Information and Instruction Series 76-44, 76-97 and 76-156.

The criteria, in the judgment of the review team, were never intended to be all-inclusive. As a result, two new criteria will be discussed in addition to the eight that were promulgated by HEW. In addition, the team considered that each of the criteria did not carry equal weight. Taken alone, a high percentage of individuals in a facility having mental impairment is more persuasive for an IMD classification than the sole fact that the facility is within a 25 mile radius of a State mental institution. Further, the fact that a facility does not meet all criteria should not derogate from a valid conclusion if the evidence taken as a whole supports a reasonable finding that the facility is an IMD within the meaning of the Statute.

Review of Facility to Determine Compliance with Bureau Guidelines

1. Licensed as a mental institution

In the entrance interview with the administrative staff of the facility, the administrator indicated that while his facility is licensed as a Rest Home with Nursing Supervision, it meets the requirements of certification as an ICF and is so reimbursed by the Medicaid program. He pointed out that his license from the Department of Health specifies "authorization to care for persons with certain psychiatric

conditions." A copy of the annual licenses from Januay 1977 to December 31, 1980 are attached. (Attachment D)

The staff of the facility stated that not only is it identified in the license but that they view the facility as a psychiatric facility. Statements were made with regard to the patient population that it consisted mostly of mentally ill patients, for the most part transferred from Fairfield Hills Hospital, a State mental institution. Also, the statement was made that local hospitals have been advised of this specialty and will specifically refer patients with mental impairments. They also reported that the general public is aware of this specialty and refer to the facility in the same terms utilized for mental institutions. Other indications were given during the interview that supported the team's conviction that the facility administration regards its license seriously and viewed itself as a licensed facility for psychiatric conditions. These other indications follow as independent criteria because they can be either documented or are so evident and persuasive that they merit individual treatment.

In any case, both from looking at the license and judging the convictions of the staff, this facility meets the criteria of being licensed as a mental institution.

2. Advertises or holds itself out as a mental institution

The administrator was asked specifically whether the facility bought any advertising in which it was stated that the facility specialized in the care of patients with mental impairments. The reply was in the negative. He stated that at some time thought was given to make [sic] some statement of the sort in the yellow pages of the telephone directory. He was not sure whether they had done so or not. The advertisement in question was looked at and simply gave the name, address and telephone number of the facility.

In this connection, he stated that the facility does hold itself out to sources of referral as specializing in mental diseases. Fairfield Hills Hospital is constantly in touch with

him (prior to the freeze on patient discharges) to accept patients. They have a well-established process whereby he and his Director of Nursing review patient records to decide whether they will be accepted. In relation to this he produced a copy of the admission policy which he has furnished the facilities that submit patients for admission. (See attachment E) Besides Fairfield Hills, he holds meetings on a frequent basis with other facilities such as Connecticut Valley Hospital, the VA Hospital and Middlesex Hospital, to review patients for admission. The patients considered for admission from the above hospitals are usually mental patients.

As partial verification of the statements made above, a call was placed to Middlesex Hospital (located in Middletown) describing the need of care for a patient with a mental condition and asking for information on facilites giving such care. Middletown Haven Rest Home was named after some discussion about State institutions.

The judgment of the team is that Middletown Haven, while it does not advertise itself in the media as such, does advertise itself to sources of referral and does hold itself out as a facility specializing in the care of persons with mental diseases.

3. More than 50% of the patients have a disability in mental functioning

Of all the criteria considered indicative of a facility "primarily engaged," this is the one deemed most persuasive when documented. The psychiatrist on the review team designed and led the review of the data upon which determinations were made that patients in the facility were "individuals with mental diseases" as stated in the regulations.

The primary document for the review is the facility's log of all the patients admitted into the facility from January 1977 to December 18, 1979. There is a duplication of

numbers because some patients were admitted and discharged several times in that time span. A second document was secured which reports, to the Connecticut Department of Health, the patients in the facility within one reporting year. A third document consists of the claims paid by the Department of Income Maintenance at monthly intervals for the Medicaid eligible patients in the facility. From all of these lists, an unduplicated list of patients was compiled for which a determination of "mental illness" had to be made. The number of patients deemed to have been in the facility since January 1977 is 469.

The psychiatrist on the team reviewed the available data. He ran a test sample under his direction that followed the following instructions. He, the nurse and the program specialist on the team would review the same patients from the admission logs, reports to the Department of Health and patient records and arrive at individual determinations. The program specialist would only consider patients with obvious mental disabilities with the following criteria: the only diagnosis is a clearly mental diagnosis and the patient was previously a patient in a mental hospital. He and the psychiatric nurse would go beyond this criteria and review the complete record on the patient and consider all the criteria to include history, diagnosis, treatment (including medications), professional nurses notes, etc. It was intended that the same patient would be reviewed more than once from different records by the same reviewer and from the same record looked at by different reviewers. Of 74 records reviewed in the sample, all three reviewers arrived independently at the same determination. For the remaining 395 patients, it was then decided that the above process was valid and clear cases were to be decided by the program specialist and the remainder by the other two members with detailed and in-depth review of patient records. Where there was even the slightest possibility of a question, the case was referred to the psychiatrist for his in-depth review and final determination. The psychiatrist

reviewed a random number of clear determinations to confirm that a proper determination was made.

Of the 469 patients deemed to have been patients in the facility from January 1977 to December 18, 1979, 364 or 77% were found to have a mental illness in accordance with major mental disorders listed in ICF-8, DSM II and all major textbooks of psychiatry. (See consulting psychiatrist's report, Attachment F).

In view of the above, it is the finding of the team that this facility is "primarily engaged" within the meaning of the regulations as caring for persons, far in excess of 50%, with diagnoses of mental illness.

As additional confirmation, we refer to the findings of independent professional reviews (IPR) performed by State teams during the same period and reported under criteria #10 and the findings of the Medical Review Team reported under criteria #8.

4. Used by mental hospitals for alternative care

Every facility in Connecticut must submit each year an Annual Patient Roster to the Department of Health, the licensing agency. The roster, among other information, contains the date of admission, where the patient is admitted from, the diagnosis, the date of discharge and the destination upon discharge.

The facility rosters show that from January 1, 1977 through December 18, 1979 239 patients were admitted from three State mental institutions: Connecticut Valley Hospital, Fairfield Hills Hospital and Norwich State Hospital. This represents in excess of 50 percent of total admissions over the same period. Further, the roster for the period October 1, 1977 through September 30, 1978 shows that 167 were admitted from the three State facilities. Of the 167, 88 or 50% were discharged from the facility during the year. Of those 88 patients more than half, 56, were re-

turned to the mental institution whence they came. Of some significance is the length of stay of these patients in Middletown. The shortest stay was one day and the longest was thirteen months. More than 90 percent stayed less than eight months and nearly 70 percent stayed less than 3 months.

While 56 of the 88 patients discharged returned to the orginal institution whence they came, only 7 of the remaining 32 were returned to a community setting. The remainder were discharged to other institutional settings.

The above shows that the State mental institutions have utilized this facility as an alternative care setting by reason of the number of patients they have placed in the facility; [sic] by reason of the large percentage that have been returned to them and by the few that have been returned to community living.

It is the finding of the team that this criteria [sic]has been strongly met.

5. Admitted mental patients from the community that may otherwise have entered a mental hospital

We have indicated above that a large proportion of patients come from State mental institutions (167). Of the remaining patients with diagnoses of a major mental illness classification in the facility between October 1, 1977 and and September 30, 1978, 42 came from a large variety of institutions (hospitals, SNFs, ICFs, residential facilities and private homes). These patients have diagnoses of a major mental illness classification similar to those admitted from State institutions. Of these, 14 come from Middlesex Hospital, the local hospital, mentioned in Criteria 2 of this section where this facility has held itself out as a mental facility. The remaining 28 come from ten other facilities throughout the State and New York. Four (4) came directly from their own home.

By reason of the considerable number of patients with mental disorders being admitted from private settings as well as the large number of community settings from whence they come, it is concluded that this facility cares for patients that otherwise might be admitted to mental institutions.

6. Proximity to a state mental institution

Middletown Haven Rest Home is within three miles of Connecticut Valley Hospital, a State mental institution. It is within forty miles of Fairfield Hills Hospital, another similar State facility, and a comparable distance from Norwich State Hospital in another direction.

Proximity is a relative thing. This criteria has defined proximity as a 25 miles [sic] radius. In a very compact State such as Connecticut, with a system of super highways that intersect the State in all directions, combined with the habits of a very mobile population, an additional fifteen miles would not be unreasonable as meeting the definition of proximity.

The fact is that these three facilities have discharged a large number of patients into Middletown Haven Rest Home. Indeed, Fairfield Hills, roughly forty miles away, has discharged into this facility at nearly a 2 to 1 ratio to the next-door facility, Connecticut Valley. During the period October 1, 1977 through September 30, 1978, the Annual Patient Roster mentioned earlier disclosed that 167 of the 356 patients or 47 percent admitted to the facility came from the three State Mental Institutions (Connecticut Valley—59 patients, Fairfield Hills—101 patients, Norwich State—7 patients).

The above data shows [sic] that from State mental hospitals alone, during this period, Middletown Haven has received nearly half of its patients.

The review team finds that while this criteria [sic] is not the most persuasive geographically viewed, it is amply demonstrated that this factor was operative in the growth of the patient population in this facility and the fact that it became primarily a population of patients with mental diseases.

7. Age distribution is uncharacteristic of nursing home patients

The administrator of the facility estimated that his patient population between the ages of 21 to 65 was probably around two-thirds.

Of the 469 patients admitted to the facility for the period January 1, 1977 through December 18, 1979, we found that 295 were over 21 and under 65, representing 64 percent of the patient population. National statistics have shown that the aged consume consistently the largest portion of the ICF services. HCFA's 1979 revised edition, "Data on the Medicaid Program", shows that the aged accounted for 63 percent of the Medicaid expenditures in ICFs. The remaining thirty-seven percent is distributed among the AFDC Adults, AFDC Children, the Blind and the Disabled which are the program catagories in which the 21-65 Medicaid population would be found. This makes it clear that the distribution is exactly reversed and therefore, uncharacteristic in this facility. In addition, the average age of patients in long-term care facilities in the United States is 82.

Additional data collected in the review further confirm the presence of an uncharacteristically young population in what is deemed to be a long term care facility. One, in the section under criteria #3, our data collected from the annual patient rosters shows that 469 patients resided in the facility over less than a three-year period indicating that an unusually large number had significantly brief stays in the facility. In Criteria #4, the length of stays are [sic] seen to be unusually brief when they are examined

specifically. A high mobility of patients in and out of the facility confirms that presence of an uncharacteristically young population. Two, in the IPR performed by the State Team in June 1978 the general comment is made:

> "Since the Team's last visit many new patients have been admitted to Middletown Haven. There appears to be a younger than usual patient population in this ICF."

The team, based on the above, finds that the patient population in this facility is uncharacteristic of those usually found in a nursing home.

8. Basis of Medicaid elegibility for patients under 65 is due to a mental disability exclusive of services in an institution for mental disease.

The only basis on which an individual can qualify for nursing care under Medicaid between the ages of 21 and 65 is if that individual is blind or disabled, exclusive of services in an institution for mental disease. Determinations of disability are made by the State agency's Medical Review Team.

There were 295 individuals between the ages of 21 and 65 who were patients at Middletown and for which Medicaid payments were made. Twenty individuals were selected at random. The case files were drawn by the staff at Middletown District Office. For this sample, only those cases were deemed disabled on the basis of a psychiatric finding if the primary or single diagnosis were a major category of mental disease. On the basis of this sample, 13 of the 20 individuals (65 percent) were found disabled on the basis of a psychiatric condition.

Since other parts of our review showed that nearly half of Middletown patients came directly from State mental institutions (Criteria #4) and 77 percent of the total patient population have a significant mental illness (Criteria #3), we believe that this sample is a reliable indicator.

The team finds that the group of patients between 21 and 65 are eligible for Medicaid on the basis of a mental illness.

9. Hires staff specialized in the care of the mentally ill

Middletown Haven, in keeping with its stated intent to treat the mentally ill, hires medical and other staff with specialized training and experience in the care of such disabilities.

The facility hires, on a contractual basis, three physicians to provide services to its patients. All three are psychiatrists. The contract entered into specifies the following:

1. That the psychiatrist be an active medical staff member,
2. That the psychiatrist come in at least weekly for consultation on patients, and
3. That the psychiatrist participate in in-service education programs for the staff.

Discussion with the facility's staff disclosed that the nurses and aides hired are usually selected on the basis of background and experience in psychiatric facilities. All have had some training and understand at the time of hiring that the patients are primarily mentally ill.

Even the non-medical staff, such as recreation and craft directors, maintenance and other support services, cafeteria workers and volunteers—all are informed at the time of hiring of the emphasis on psychiatric conditions and are selected on their ability to deal with this fact.

Each employee has participated in some in-service training designed to develop and support their ability to relate to the mentally ill. All have access to the psychiatrists on a one-to-one basis if any problems develop around the care of a particular patient. With regard to the nursing staff, a recent training session dealt with the management, dis-

pensing and control of psychotropic drugs. There are in-house group therapy sessions held regularly in which both patients and staff members participate.

Our conclusion is that this facility very clearly hires and trains staff for the care and treatment of mental illnesses.

10. Independent professional reviews conducted by state teams report a preponderance of mental illness patients in facility

Four IPRs were conducted by State teams since the opening of this facility in January 1977. These reviews were conducted at approximately six-month intervals.

The patient assessment forms contain the diagnosis, medication and brief history of condition. In all cases of mental illness diagnosed, the history and medications are consistent with the diagnoses reported. The general comments on the entire facility administration often focus on drug control and management. The psychotropic drugs used, in relation to the size of the facility, suggests and supports [sic] the presence of a high percentage of mentally ill patients.

The diagnoses most frequently reported for the patients are:

—schizophrenia, chronic, undifferentiated
—simple schizophrenia
—paranoia
—psychotic depressive reaction
—depression psychosis
—acute dissociative reaction
—manic depressive psychosis
—catatonic schizophrenia
—alcoholism with acute brain syndrome

The general comments in the IPR reports refer frequently to the high incidence of psychiatric patients and recommendations often emphasize the need for increased group therapy sessions.

The number and percentage of patients with diagnoses of mental illness at the time of four IPRs are as follows:

Title XIX Patients

Total Patient Occupancy	Total	No. With Mental Diagnosis	% of Total Patient Occupancy With Mental Diagnosis
56	51	31	55
154	149	89	58
172	166	114	60
177	172	119	67

The team finds that at the time of the IPRs the evidence supports the presence of patients with clearly-established mental illnesses in excess of 51 percent of the patient population.

SUMMARY

In summary, the team has determined that Middletown Haven Rest Home is an IMD within the framework of all applicable Federal laws, regulations, and guidelines. As such, this institution is primarily engaged in providing psychiatric services to residents with a mental illness.

Section 1905 (a)(vi)(14) and (16) of the Social Security Act permits the States the option to provide psychiatric services for individuals 65 and over and under 21 years of age and Section 1905(a)(vi)(17)(B) precludes these same services for those individuals that are between the ages of 21 and 65.

The State of Connecticut, however, has not elected to cover IMD services under its State Plan; therefore, all payments made to this facility by the State agency are ineligible for Federal matching. In addition, the State Agency's claim directly violated Section 1905(a)(vi)(17)(B) as no provision was made to eliminate the payments made on behalf of the patients between 21 and 65 years of age.

In our opinion, these deficiencies evolved because the State agency had not established procedures to properly identify those facilities which meet the definition of an IMD and to specifically identify the expenditures associated with these facilities for exclusion in its Quarterly Statement of Expenditures.

Recommendations and State Agency Comments

We recommend that the State agency:

1. Adjust the next Quarterly Statement of Expenditures (HCFA Form-64) by $3,269,310 (Federal Share $1,634,655) to reflect the total Federal financial participation applicable to Middletown Haven Rest Home for the period January 1, 1977 through September 30, 1979.
2. Exclude from future Quarterly Statement of Expenditures all payments to Middletown Haven Rest Home commencing with the quarter ended December 31, 1979, until such time as the State modifies its State plan to include IMD services. If the State modifies its State plan, procedures will need to be established to identify and exclude payments made on behalf of residents between 21 and 65 years of age.
3. Establish procedures to identify those facilities which meet the definition of an IMD.

State agency officials preferred not to make any official comments on the draft report. They indicated that they will continue to study the report and respond to it at a later date. (See APPENDIX)

ATTACHMENT A

STATE OF CONNECTICUT

Department of Mental Health

August 6, 1979

Regional Medicaid Director
Medicaid Bureau
Department of Health, Education,
and Welfare, Region I
J. F. Kennedy Federal Building
Boston, Massachusetts 02203

Please find enclosed a copy of the Department of Mental Health policy regarding discharge and placement of patients from DMH facilities into skilled nursing facilities. This policy was promulgated last Friday in response to your request and as noted in Commissioner
letter to you of August 2.

I would appreciate any thoughts or comments about the policy which you may have, and I look forward to working with you towards resolving the other difficulties that we have been discussing.

Sincerely yours,

Commissioner

Enclosure

STATE OF CONNECTICUT

Department of Mental Health

August 3, 1979

COMMISSIONER'S POLICY STATEMENT NO. 14

DISCHARGE AND PLACEMENT OF PATIENTS FROM DMH FACILITIES INTO SKILLED NURSING FACILITIES

The following principles will be observed around the discharge and placement of all DMH patients at any Skilled Nursing Facility:

1. The patient must no longer require hospital care.
2. Placement in a SNF must be deemed the least restrictive alternative for providing appropriate care to the specific patient.
3. The patient must require the services of a SNF in specific ways such as:
   a. Patient has a chronic medical condition requiring continuing nursing observation and care.
   b. Patient is in process of physical and brain deterioration and requires continuing and increasing nursing care.
   c. Patient is convalescing from a medical/surgical illness and required [sic]continuing nursing care.
   d. Patient has severe physical limitations requiring a contained environment and assistance with the vital functions of daily living and medications.
   e. Patient has a chronic mental illness, not requiring hospitalization, but so disabling as to require continued nursing supervision, medication, and care in order to maintain physical safety and well-being.

f. Patient is a fragile elderly person with a complex of geriatric problems requiring continuing nursing supervision and care.

g. Patient is physically or mentally incapable of moving with reasonable speed without assistance to a place of safety outside the building.

4. Placement in a SNF must be recommended and planned for in the patient's individual discharge plan as determined by the responsible treatment team.

5. The individual patient's clinical condition and need for services must fit the specific SNF in terms of nursing services, ancillary services, environment, activities, and behavioral control. A part of this determination will be firsthand knowledge of the SNF by a person with responsibility for the placement to ascertain the specific fitness of the placement. The patient and/or family, as appropriate, will be oriented to possible specific placements, preferably by visit, and the patient and/or family will participate in the final selection and agree to the placement.

6. Follow-up for appropriateness and adaptation will be done by placement personnel by visit within one month and otherwise as indicated.

7. A patient placed in a SNF from a DMH facility will, if rehospitalization is required, be returned to the DMH facility from which placed, regardless of regional boundaries. Exceptions for compassionate or practical reasons may be made by the Superintendents involved.

Commissioner

ATTACHMENT B

HCFA December 2, 1979

Department of Mental Health
90 Washington Street
Hartford, Connecticut 06615

This is to acknowledge receipt of your letter of October 1, 1979, in which you enclosed the report of the review of former Department of Mental Health patients at Lorraine Manor. The report is in partial fulfillment of the agreement we made at our meeting of July 18, 1979, that all the patients discharged from DMH facilities in the past three years would be evaluated for appropriateness of placement.

We also acknowledge receipt of the statement of Policy No. 14 which you developed at our request to govern discharges of DMH patients into skilled nursing facilities. We took some time to analyze this document in order to measure its implications against the requirements of all pertinent Federal regulations. Because of the role this statement of policy plays in the evaluation of patients for appropriateness of placement in SNFs it is important that we discuss both documents in this letter.

Our first difficulty with the policy statement comes up with Item 3 taken as a whole. We do not believe that the wording makes it clear enough that more than one item of need would normally apply to each patient and that all of them should be taken into account and found applicable or non-applicable prior to discharge.

With regard to the specific items listed from a. through g. under number 3, we have no problems with Items a. through e. and we find that these conform to generally accepted criteria for placement into skilled nursing facilities. Critieria [sic] f., however, describes an old person with the problem usually attendant upon old age. Taken alone, it would not qualify a patient for skilled care but rather for

long term care in an intermediate care facility. In a patient with a history and probably a continuing condition of mental illness we would hardly envision seeing criterion f. stand alone in any evaluation. This would suggest to us an old argument that we have already deemed unacceptable that the mental illness somehow ceases to become a factor of special care when the patient reaches the magic age of sixty-five. The last criterion listed as g. under item 3 is absolutely unacceptable as a criterion for placement in skilled nursing facilities. This is the wording of a provision of the Connecticut Public Health Code which we have found to be out of compliance with Federal regulations for skilled nursing facility level of care. This office has raised this issue officially and has found the State out of compliance requiring on-going negotiations to resolve the issue.

The second document is the report of the review of every mental health patient at Lorraine regarding which you invited my thoughts and comments. The format of the report makes it difficult for anyone not having access to the working papers to evaluate how decisions, regarding appropriateness of placements were reached and what supports the overall findings. Also, if our analysis is correct, the criteria utilized in the evaluation are the ones contained in your policy statement. While we agree that using those criteria was essentially appropriate, to the extent we disagree with some of them will probably account for corresponding differences in the way we view the results of the evaluation.

With these two prefacing statements in mind, we must express some difficulty with accepting the general findings. Looking at the bareboned documentation furnished, we find it difficult to understand the relatively small number of 3e's assigned by the Committee to a group of patients that other information available to me describes as psychotic with diagnoses of schizophrenia, dementia precox, etc. in much larger percentages. Secondly, we find that the

criteria f. and g. appears [sic] unduly frequently and would not support the appropriateness of placement into a skilled nursing facility, as we have said earlier. Yet, the Committee has found that more than 90 patients out of 109 have either been appropriately placed initially or were properly placed at the time of the review. We believe that this outcome raises serious questions as to the acceptability of the review for the purposes we had mutually intended.

Mindful that these questions cannot be satisfactorily resolved in a letter, I have directed my representative in Connecticut, to contact you in order to arrange a meeting with you and the Committee and to perform a review of the documentation for the Lorraine Manor evaluations. He will be accompanied in this review by a psychiatrist from our Public Health Service. The purpose will be to develop a better actual understanding of the issues and a reconciliation of our differences in viewpoint. It is my conviction that this is essential before further reviews are made in all the other facilities. It will be important that these issues be resolved as soon as possible and it is my expectation that you will assist them in every way possible. It is anticipated that this review can easily be accomplished within the space of two days.

The purpose of our working together is to enable the restoration at the earliest possible time of Federal funds now being withheld in an amount approaching $1 million. What has been accomplished to date, while gratifying, is not nearly enough to permit me to restore those funds that are viewed as vital to the successful management of the Medicaid program in Connecticut.

It is incumbent on me, also, to make clear to you what remains to be done of the agreement we had reached at our meeting on July 18, 1979. You were to make available to me a list of patients discharged from DMH facilities into SNFs for the past three years, which has not yet been received. Since Mr. will be meeting with you shortly, you

can work out the details with him and make it available at that time.

Finally, you have agreed to review all DMH patients in other facilities. The pace of the reviews could become a real problem to the Department of Income Maintenance if they are not completed with more speed than the one done at Lorraine Manor. Would you inform me as soon as possible of the date you expect to complete the reviews so that I may give Commissioner ____ a tentative target date for resumption of Federal funds.

This letter, of necessity, has concentrated on areas of apparent differences. I would be remiss, however, if I did not express my appreciation for the significant efforts you have made to date to meet the Federal requirements. That continuing spirit of cooperation will assure success to the tasks that remain to be done.

Should you have any questions regarding this letter, you may call me or ____ at (617) 223-6881.

Sincerely yours,

Regional Medicaid Director

ATTACHMENT C

14.a. Services for individuals age 65 or older in institutions for tuberculosis		
(1) Inpatient hospital services	☐ Provided ☐ No limitations ☐ With limitations* ☒ Not provided	☐ Provided ☐ No limitations ☐ With limitations* ☒ Not provided
(2) Skilled nursing facility services	☐ Provided ☐ No limitations ☐ With limitations* ☒ Not provided	☐ Provided ☐ No limitations ☐ With limitations* ☒ Not provided
(3) Intermediate care facility services	☐ Provided ☐ No limitations ☐ With limitations* ☒ Not provided	☐ Provided ☐ No limitations ☐ With limitations* ☒ Not provided
14.b. Services for individuals age 65 or older in institutions for mental diseases		
(1) Inpatient hospital services	☒ Provided ☒ No limitations ☐ With limitations* ☐ Not provided	☒ Provided ☒ No limitations ☐ With limitations* ☐ Not provided
(2) Skilled nursing facility services	☐ Provided ☐ No limitations ☐ With limitations* ☒ Not provided	☐ Provided ☐ No limitations ☐ With limitations* ☒ Not provided
(3) Intermediate care facility services	☐ Provided ☐ No limitations ☒ With limitations* ☐ Not provided	☐ Provided ☐ No limitations ☐ With limitations* ☐ Not provided

*Description provided on attached sheet

ATTACHMENT C

ATTACHMENT D

License

Rest Home with Nursing Supervision

In accordance with the provisions of Section 19-33 of the 1952 Revision of the General Statutes
Middletown Haven Rest Home of Middletown Connecticut,
(Mr. Raymond Cyr, Adm.)
is hereby granted permission to maintain and operate a rest home with nursing supervision, known
as Middletown Haven Rest Home at 111 Church Street
in the City / Town of MIDDLETOWN Connecticut, with
Arnold Berman M.D., of Chester as Consulting Physician
and Patricia Sandford, R.N. of Wethersfield as Resident Nurse in Charge

The maximum number of persons cared for shall not exceed 180 at any one time.
This license expires Dec. 31, 1980 and may be revoked for cause at any time.
Dated at Hartford, Connecticut, this 1st day of January, 1980
No. 135-RH

Authorization to care for persons
with certain psychiatric conditions

Douglas L. Lloyd, M.D.
Commissioner of Health

CONNECTICUT STATE DEPARTMENT OF HEALTH
Form HS-33

ATTACHMENT D

License

REST HOME WITH NURSING SUPERVISION

In accordance with the provisions of Section 19-13 of the 1958 Revision of the General Statutes
Middletown Haven Rest Home of Middletown Connecticut,
(Mr. Raymond Cyr, Administrator)
is hereby granted permission to maintain and operate a rest home with nursing supervision, known
as Middletown Haven Rest Home at 111 Church Street
in the City Town of MIDDLETOWN Connecticut, with
Arnold Berman M.D., of Chester as Consulting Physician
and Patricia Sandford, R.N. of Wethersfield as Resident Nurse in Charge

The maximum number of persons cared for shall not exceed 180 at any one time.
This license expires Dec. 31 1979, and may be revoked for cause at any time.
Dated at Hartford, Connecticut, this 1st day of January 1979

No. 135-RH

Authorization to care for persons
with certain psychiatric conditions

Douglas S. Lloyd, M.D.
Commissioner of Health

CONNECTICUT STATE DEPARTMENT OF HEALTH
Form HR-12

ATTACHMENT D

License

REST HOME WITH NURSING SUPERVISION

In accordance with the provisions of Section 19-13 of the 1958 Revision of the General Statutes
Middletown Haven Rest Home of Middletown, Connecticut,
(Dr. Raymond Lublin, Administrator)
is hereby granted permission to maintain and operate a rest home with nursing supervision, known
as Middletown Haven Rest Home at 111 Church Street
in the City / Town of MIDDLETOWN, Connecticut, with
Louis LaBella M.D., of Middletown as Consulting Physician
and Mrs. Patricia Sandford, R.N. of Wethersfield as Resident Nurse in Charge

The maximum number of persons cared for shall not exceed 180* at any one time.
This license expires Dec. 31, 19 78, and may be revoked for cause at any time.
Dated at Hartford, Connecticut, this 1st day of January, 19 78

No. 135-RH

*Inc. in bed capacity - 2/3/78

Authorization to care for persons
with certain psychiatric conditions

Douglas S. Lloyd, M.D.
Commissioner of Health

CONNECTICUT STATE DEPARTMENT OF HEALTH
Form HS-13

ATTACHMENT D

License

REST HOME WITH NURSING SUPERVISION

In accordance with the provisions of Section 19-33 of the 1958 Revision of the General Statutes Middletown Haven Rest Home of Middletown Connecticut, (Dr. Raymond Lublin, Administrator) is hereby granted permission to maintain and operate a rest home with nursing supervision, known as Middletown Haven Rest Home at Middletown in the City Town of MIDDLETOWN Connecticut, with Louis LaBella M.D., of Middletown as Consulting Physician and Mrs. Patricia Sandford, R.N. of Wethersfield as Resident Nurse in Charge

The maximum number of persons cared for shall not exceed 120 at any one time.
This license expires Dec. 31 19 78 and may be revoked for cause at any time.
Dated at Hartford, Connecticut, this 1st day of January 19 78

No. 135-RH Authorization to care for persons with certain psychiatric conditions

Douglas S. Lloyd, M.D.
Commissioner of Health

CONNECTICUT STATE DEPARTMENT OF HEALTH
Form HS-19

ATTACHMENT D

License

Rest Home with Nursing Supervision

In accordance with the provisions of Section 19-13 of the 1958 Revision of the General Statutes
Middletown Haven Rest Home of Middletown, Connecticut,
(Dr. Raymond D. Lublin, Administrator)
is hereby granted permission to maintain and operate a rest home with nursing supervision, known
as Middletown Haven Rest Home at 111 Church Street
in the City/Town of MIDDLETOWN, Connecticut, with
Dr. Louis LaBella M.D., of Middletown as Consulting Physician
and Mrs. Patricia Sandford, RN of Manchester as Resident Nurse in Charge

The maximum number of persons cared for shall not exceed 120* at any one time.
This license expires Dec 31, 1977 and may be revoked for cause at any time.
Dated at Hartford, Connecticut, this 19th day of January, 19 77

No. 135-2H
Authorization to care for persons
with certain psychiatric conditions

*Increase in bed capacity 6/13/77

Douglas S. Lloyd, M.D.
Commissioner of Health

CONNECTICUT STATE DEPARTMENT OF HEALTH
Form HS-19

ATTACHMENT D

License

Rest Home with Nursing Supervision

In accordance with the provisions of Section 19-22 of the 1952 Revision of the General Statutes
Middletown Haven Rest Home (Dr. Raymond D. Lublin, Administrator) of Middletown, Connecticut,
is hereby granted permission to maintain and operate a rest home with nursing supervision, known
as Middletown Haven Rest Home at 111 Church Street
in the City/Town of MIDDLETOWN, Connecticut, with
Dr. Louis LaBella M.D., of Middletown as Consulting Physician
and Mrs. Patricia Sandford, R.N. of Manchester as Resident Nurse in Charge

The maximum number of persons cared for shall not exceed 60 at any one time.
This license expires December 31, 19 77 and may be revoked for cause at any time.
Dated at Hartford, Connecticut, this 18th day of January, 19 77

No. 135-RH
Authorization to care for persons with certain psychiatric conditions

Douglas D. Lloyd, M.D.
Commissioner of Health

CONNECTICUT STATE DEPARTMENT OF HEALTH
Form HH-29

ATTACHMENT E

ADMISSION POLICY

All admissions will be based on patients [sic] needs. All patients must be certified to be ambulatory and able to care for themselves. All admissions will be made without regard to race, color, creed or sex on a space available basis. The physician will be notified upon admission and will see the patient within 24 hours. All admissions will be accompanied by a W-10 (Inter agency Patient Referral Form) signed by Physician. No person suffering from Communicable Disease, Critically ill or acute mental disorders, maternity residents, acute drug addicts, acute alcoholics, or requiring 24 hour nursing care will be admitted.

Patients Rights

If after three attempts at obtaining the necessary signature on the Patient's Bill of Rights, the Administrator will sign for the patient and note the reason.

Patients Complaints and Grievance Procedure: 249.12(a)(ii)(c)

Any resident, their spouses, the public or employees of Middletown Haven Rest Home may register a complaint or grievance without threat of discharge or other reprisal. A resident wishing to air a complaint or grievance may go through the Resident's Council, through the Director of Nurses or through the Administrator. All complaints will be kept confidential.

The Residents [sic] Council is opened to all the residents and meets tentatively every first Thursday of the month. The council meeting is held directly after the council meets with the Administrator and all other heads of departments to answer questions posed by the residents from their previous month's meeting.

Complaints may be given in writing or verbal. [sic] A record of the complaint will be kept in a file in the Administrators [sic] office.

Requirements for Admission:

Residents shall be admitted only on referral from a responsible source. No resident may be admitted on an emergency basis except in the event of a major disaster, in which case the State Dept. of Health shall be notified at the earliest possible time.

Sufficient information must be received pertaining to resident's condition by the person responsible for resident's admission to determine if such person is eligible for a Rest Home with Nursing Supervision.

A. Prior to admission a written statement shall be obtained from a physician licensed to practice medicine and surgery in Connecticut, stating that the resident does not need twenty-four hour nursing care. This statement is kept on resident's chart at all times.

B. No person who is physically and mentally incapable of making his own way, without assistance to the place of safety outside of the building, shall be housed in the institution. If the resident uses assistance in walking—such as a cane, crutch, walker—it must be for security reasons and noted as such on the chart.

C. No resident shall be admitted if in need of twenty-four nursing care. Residents shall be transferred if they develop a need for twenty-four [sic] nursing service.

D. No person under 16 years of age shall be admitted to the institution.

E. All residents coming from a psychiatric hospital or mental retardation center must have a copy of a [sic] clinical and social summaries. In addition, those residents coming from a mental hospital or those with a psychiatric background must have [sic] written statement that they are not

dangerous to themself [sic] or others, or property signed by a board certified psychiatrist.

F. All residents with contagious diseases, acute drug addicts, maternity residents, and acute mental disorders as well as residents who might need chronic or convalescent care will not be accepted for admission.

MEDICAL RESPONSIBILITIES AT TIME OF ADMISSION & DISCHARGE

A. Complete physical examination by physician within 24 hours, unless performed within 5 days prior to admission and a copy of such findings made available for the facility's charts and medical history.

B. Admission orders to be filled out in accordance with State laws and signed by physician. The orders must include the following information: medications, treatments, restorative services, diet and activities.

C. Prior to or on admission a written statement shall be obtained from a physician licensed to practice medicine and surgery in Connecticut, stating that the resident does not need twenty-four hour nursing care.

D. Before a resident can be discharged from the facility to home or to any other facility, there must be a discharge order from the resident's physician. In the case of an emergency transfer to a hospital, the discharge order may be given by the physician covering the facility on an emergency basis, if a resident wishes to leave the home without the consent of his physician he will be asked to sign a release of responsibility.

ATTACHMENT F

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service

DATE: January 3, 1980

To: Medicaid Program
Specialist

FROM: Psychiatrist Consultant, DoADAMHP

SUBJECT: Medicaid Sponsored Trips to Connecticut

Thank you for the opportunity to inspect Lorraine Manor on November 14-15, 1979 and Middletown Rest Haven, on December 17-18, 1979 with your Medicaid Team.

My observations and conclusions regarding *Lorraine Manor*:

> An overwhelming majority of patients on the mental health floor in this SNF did have major diagnoses of mental illness, were appropriately placed in a setting substantially more restrictive than a state mental hospital, were undoubtedly receiving care of their many physical conditions superior to that received in a state hospital, but would benefit from more regular care from consulting psychiatrists to monitor the use of and need for psychotropic medication, and to monitor and evaluate the changing needs of patients for a movement to either more or less restrictive medical and psychiatric settings. A sample of ten charts was inspected randomly, and five of these ten patients were briefly interviewed. The facility was clean, well equipped and clearly superior clinically and more cost effective than a state mental hospital.

My observations and conclusions regarding *Middletown Rest Haven*:

> All charts (52) from the patient population on the fourth floor were inspected and data collected on source of referral, diagnoses, medications, nursing

> notes and documentation of continuing need for placement in this ICF. All additional charts for other current and former patients were also examined except for those cases where the facility's own patient log indicated a major or primary diagnosis of schizophrenia, manic-depressive illness, or personality disorder. All charts with diagnoses of alcoholism and organic brain syndrome were examined and counted as case of mental illness where the record indicated that the psychiatric causes, complications or sequelae of these disorders were a significant part of the patients [sic] ongoing need for ICF placement. Patient records were uniformly legible, complete, well organized and entirely adequate to permit a determination of the presence or absence of mental disease as a significant justification for ICF placement.
>
> The overwhelming majority of both current and former patients have documented mental illness that is a substantial part of their need for ongoing ICF care. This conclusion would still be valid if the patients with primary diagnoses of alcoholism and organic brain disease were excluded from the totals. The justification for their inclusion is their appearance as major mental disorders in ICD-8, DSM II and all major textbooks of psychiatry, and the fact that the State of Connecticut treats this class of the mentally ill in its state mental hospitals in general, not specialized, care settings.
>
> With the exception of perhaps 10 of the current patients, all those with significant mental illness were determined to be appropriately placed. Fifty percent of these, however, are only now placed appropriately because of the absence of sufficient boarding homes, day treatment facilities, half-way houses, community residences and other community based and community mental health center related, transitional living and chronic care resources in Connecticut. That is, this fifty percent would be better treated and more cost effectively cared for in a variety of other facilities, if they existed.
>
> The vast majority of these ICF patients are receiving care superior to that offered by a state mental hospital.

This ICF is clean, well staffed, well administered and operating in fact as a much needed ICF/MH, though no such entity is formally recognized by current Connecticut laws or regulations or licensing procedures, or the State Medicaid Plan.

General Comment

In the deinstitutionalization game, the federal Medicaid, Medicare and PHS Offices, the state mental health and health authorities, the HSA's, CMHC's, State Mental Hospitals, general hospitals with psychiatric, alcohol or rehabilitation units, private psychiatric and detoxification facilities, and nursing and boarding home facilities, all de facto operate as a "system". The least controlled, least regulated and least responsive piece of this system are the nursing and boarding homes. Until federal and state law requires such homes to be responsible and responsive members of that "system" or to make it without public funds, the deinstitutionalization game will continue to be a shell game for private profit and inferior patient placement. Through the state plan approval mechanism, the federal Region I Offices of Medicaid and the PHS-DoADAMHP should be able to have an impact on this problem, which is by no means unique to Connecticut.

Recommendation

Consideration be given to joint consultation and to joint review of State Medicaid and Mental Health Plans by the federal Region I Medicaid Authority and the PHS Office of the RHA.

M.D., MPH

APPENDIX

STATE OF CONNECTICUT
Department of Income Maintenance

APRIL 18, 1980

ALFRED FUOROLI
REGIONAL COMMISSIONER
HEALTH, EDUCATION & WELFARE
HEALTH CARE FINANCING ADMINISTRATION
JOHN F. KENNEDY FEDERAL BUILDING
GOVERNMENT CENTER
BOSTON, MASSACHUSETTS 02203

Dear Mr. Fuoroli:

This letter is for the purpose of responding to your March 17th letter to Commissioner Maher which accompanied your draft report on Middletown Haven Rest Home. The department would prefer not to make any official comments on your draft report at this time. We will continue to study the report and expect to respond to it at a later time.

Very truly yours,

Stephen H. Press, Director
Medical Care Administration

SHP:pat

cc: Edward W. Maher
Commissioner

REPORT DISTRIBUTION

	No. of Copies
HCFA	
Regional Office	
Administrator	2
Deputy Administrator	1
Medicaid Director	8
HSQB Director	1
Central Office	
Director, Bureau of Program Policy	1
Director, Bureau of Program Operations	1
Director, Bureau of Program Operations, Office of Program Administration	1
Other Regional Offices	
Regional Medicaid Directors—Region II-X	1
GRANTEE	
Commissioner, Department of Income Maintenance State of Connecticut	2
Commissioner, Department of Mental Health State of Connecticut	1
OTHER PARTIES	
Principal Regional Official	1
HEW Audit Agency—Regional Office	1
HEW Audit Agency—Hartford Branch	1

APPENDIX B

Excerpts from the testimony of Margaret Lempitsky

UNITED STATES OF AMERICA
BEFORE THE HHS DEPARTMENTAL GRANT APPEALS BOARD

STENOGRAPHIC TRANSCRIPT OF HEARINGS IN THE MATTER OF: "INSTITUTIONS FOR MENTAL DISEASES"

Docket Nos. 79-52-MN-HC
79-89-MN-HC
80-44-IL-HC
80-150-CT-HC
80-184-CA-HC

Place: Washington, D.C.
Date: April 22, 1981.

VOLUME: 1
PAGES: 1 thru 263

[126] the review teams that conduct utilization reviews and independent professional reviews in the facilities around Connecticut.

We are presenting Mrs. Lempitsky as someone with a program perspective on the IMD issue. We think it is important to present someone who comes at this from the perspective of having to implement the IMD policy on a day to day basis.

Direct Examination by Ms. Corwin:

Q. Mrs. Lempitsky, how long have you been aware of the IMD provision?

A. Since approximately mid-seventies.

Q. And you were aware there was a statutory provision and a published regulation on the subject?

A. Correct.

Q. And how has Connecticut perceived the IMD provision? What is excluded from Medicaid coverage under Connecticut's understanding?

A Primarily we exclude the ages of 21 and 65, the state mental hospitals.

Q. How many state mental hospitals do you have in Connecticut?

A. Currently we have four.

[127] Q. And how many did you have during this period of the late 1970's?

A. Three.

MR. SETTLE: Of the late 1970's did you say?

Ms. CORWIN: That is correct, just to—

MR. SETTLE: Yes.

Ms. CORWIN: —put in perspective that there were three, but there are currently four.

BY Ms. CORWIN: (Resuming)

Q. Are there any private facilities that you also do not cover because of the IMD provision?

A. Yes. We have I think it is eight accredited psychiatric hospitals in the state.

Q And those are private facilities?

A. Private, yes.

Q. Are there any individuals for whom you provide coverage in those facilities?

A. Those that are 22 and under.

Q. Mrs. Lempitsky, in the audit report that was submitted in connection with the Middletown Haven disallowance there is a list of 10 criteria that were used to identify whether or not Middletown Haven was to be classified as

an IMD. When did you first see this list of criteria?

A. It was after—well, when a draft report came out

• • •

[129] not remember.

Q. There was also reference to a regional attorney's opinion I believe. I think Ms. Hathaway mentioned that there was something attached to audit reports, although I will note for the record note to Connecticut's audit report.

Had you ever seen something in the form of an opinion of a regional attorney interpreting the IMD provision?

A. No, I have not.

Q. When did you and others of the Department of Income Maintenance become aware that the regional office, the Federal regional people, were taking the position that it was not only state mental hospitals but also Intermediate Care Facilities and Skilled Nursing Facilities that could be classified as IMD's?

A. Roughly I would say around 1976 we had received verbal indications to that effect.

Q. Did you receive anything in writing?

A. Nothing that I can remember.

Q. What was your understanding of how the regional office thought one should go about identifying what was an IMD? Were there any elements that they transmitted to you?

A. Verbally they were—as I recall, they were looking retardation patients that were involved.

• • •

[146] Q. Can you approximate the percentage of cases that you looked at in which there were multiple diagnoses, more than one diagnosis?

A. In percentages?

Q. Just roughly.

A. I was looking in terms of the psychiatric as opposed to other writing factors, but I would have to say that—would you repeat it again?

Q. Let me rephrase it.

A. Okay.

Q. Would you say that more than half of the individuals had multiple diagnoses, more than one diagnosis?

A. I think that that is very fair.

Q. Were there individuals who had no psychiatric diagnosis at all?

A. There were some, yes.

Q. The audit report on Middletown Haven refers to the fact that a number of individuals whose records were looked at had formerly been in state mental hospitals. Did your review confirm that?

A. Definitely yes.

Q. Did you set out some of the examples of such individuals in the affidavit that you submitted with the brief that we filed?

[147] A. Yes. Yes, I did.

Q. And how did you—why did you set out those five examples in the affidavit? What was the purpose of those five examples?

A. The purpose was to show that there were patients there were psychiatric and other complicating factors, which may have overridden the psychiatric condition and therefore as far as this department was concerned would not have been classified as a psychiatric patient, but there [sic] reason for placement was other than psychiatric.

Q. Can you suggest, based on your knowledge and your responsibility for placement decisions and knowledge of reasons for placement, why it might be that someone who had originally been in a state mental hospital might then be transferred to an intermediate care facility?

A. Oh, the patient could have stabilized to the point where it would no longer be necessary for an acute psychiatric care. It could have been a burnt out case where there was no intensive treatment that was going to benefit the patient primarily.

Q. Would there be cases in which individuals had developed physical conditions while they were in state six months since the date it opened.

• • •

[150] Q. Why did you not visit Middletown Haven as a way to prepare for testimony in this hearing?

A. Well, disallowance came in after, and as a result of the disallowance and the Middletown Haven—the state decided because of the pressures brought about by the Federal Government that we would—what do I want to—what is the word I am looking for? We would—

Q. Would convert?

A. Convert Middletown Haven into an IMD by removing patients from that facility who did not belong there and having the institutions come under the jurisdiction of the Department of Mental Health.

Q. Does the facility now have solely mental patients?

A. That was arrangement, yes.

Q. Can you describe any differences that you are aware of between the facility as it existed during the period of the disallowance and the facility as it exists today?

A. It is my understanding from the administrator that they have provided a far greater degree of intensity, in terms of the services, the organization, coordination between the different disciplines, and the hospital—or excuse me, in the ICF's at Middletown Haven.

Q. When you say there is more intensity in the services, are you speaking about psychiatric services?

[151] A. Some of the psychiatric services they are having more group meetings, team meetings, involving patients. They have developed a concept now where each patient has a contact person to go to where there are particular problems, if a patient had a particular problem that he needed help with. The whole climate of the institution seems to have gone to much more of a psychiatric—maybe not an acute mental hospital—but has taken on totally psychiatric flavor.

Q. Do you know anything about the patterns of movement back and forth between the facility and a state mental hospital as it is now versus what it was during the period of the disallowance?

A. Studies at the facility done prior to the disallowance have shown I believe there was upwards to 30 percent or more recidivism rate to the state institution of psychiatric patients. Since they have adopted their new philosophy and their new programming and they have introduced it by floor, the rate has decreased to now where the first floor they have instituted a program that is a zero return rate.

Q. Let me develop for a moment your term recidivism. Are you talking about a rate at which a resident of the ICF would be returned to the state mental hospital?

[152] A. Yes, because of some acute incident or some situation where the facility could not treat that patient.

Q. Prior to the conversion of the facility then there was approximately a 30 percent return rate to the state mental hospital in the case of something like an acute incident, and now there is virtually no return to the state mental hospital?

A. That is what the facility has said, yes. That is the documentation.

Q. Let me ask you just one point I am not sure that I covered before. You described approximately eight private psychiatric facilities I believe. Did you describe anything

about their accreditation? I may have forgotten this, but if—

A. They are also accredited by the JCAH. As mental hospitals.

Q. As mental hospitals?

A. As mental hospitals.

Q. And those are facilities that you do not cover under your Medicaid program, is that right?

A. Right.

Q. With the exception of the under 22.

A. Under 22.

APPENDIX C

Excerpts from the Testimony of Lawrence W. Osborne

UNITED STATES OF AMERICA
BEFORE THE HHS DEPARTMENTAL GRANT APPEALS BOARD

STENOGRAPHIC TRANSCRIPT OF HEARINGS IN THE MATTER OF: "INSTITUTIONS FOR MENTAL DISEASES"

Docket Nos. 79-52-MN-HC
79-89-MN-HC
80-44-IL-HC
80-150-CT-HC
80-184-CA-HC

Place: Washington, D.C.
Date: April 23, 1981.

VOLUME: 2
PAGES: 264 thru 449

[309] Whereupon,

LAWRENCE W. OSBORNE

was called as a witness, and upon examination testified as follows:

DIRECT EXAMINATION BY MR. ENG:

Q. Will you state your name?

A. Lawrence W. Osborne.

Q. What is your present job?

A. I am the Acting Director of the HCFA Regional 1 Boston Health Care—Health Standards and Quality Bureau. My permanent position is the Director of the Division of that bureau's survey and certification operation.

Q. And what was your previous job?

A. Prior to April 16, 1980, I was the Director of the Special Programs Unit in the Public Health Services Regional Office of the Division of Alcohol and Drug Abuse and Mental Health Administration.

Q. Now, you are an M.D.?

A. Yes.

Q. With a degree from where?

A. Cornell University Medical College.

Q. What year?

A. 1967.

[312] CHAIRMAN SETTLE: All right.

BY MR. ENG: (Resuming)

Q. Now, Dr. Osborne, what you did at the facility involved a number of intricate steps. How did you start?

A. We started by interviewing the administrator and the director of nursing services for Middletown Rest Haven, and—

Q. At some point did you have occasion to determine what kind of a medical staff the facility had?

A. Yes.

Q. In terms of permanent medical director or consultants?

A. The medical director was not a board eligible psychiatrist, but was a licensed general practitioner in Connecticut. The three medical consultants retained by the facility through contract, which we examined the contracts, were all board eligible, if not board certified psychiatrists.

Q. Did you verify that information with anyone at the facility?

A. Well, subsequently—actually yesterday afternoon—I called the administrator and again verified that they were

in fact at least board eligible psychiatrists—those three outside medical consultants.

[313]Q. Now, did you have occasion to review the—review any medical records at the facility?

A. Yes. We started—Ms. McGilvery and myself—by examining all the medical records regardless of diagnosis, regardless of source of referral—on the fourth floor.

Q. How many records?

A. That was 52 records.

Q. Now, did you evaluate those together or independently?

A. We evaluated them independently and then checked to see how many we agreed on in terms of who we could responsibly call in the category of mentally disturbed or being primarily placed there for reasons of their mental status.

All but three we agreed upon and very briefly, after observing the patients, discussing the record again in even greater depth, and in talking with the director of nurses who was very helpful,—

Q. You mean the director of nursing at the facility?

A. At the facility, yes. We agreed on those three very quickly.

Q. Now, the director of nursing at the facility, do you remember her name?

A. Yes. Mrs. Patricia Sanford.

[314] Q. Do you know whether she was familiar with the patients?

A. She was intimately familiar with all the patients. I was quite impressed with her knowledge of what was going on with each patient.

Q. And you are saying you discussed some of the cases with her?

A. Yes. We actually used her opinion throughout for I would say a very small—less than one percent of all the patients—where we had some questions about deciding one way or the other, based on the evidence in the medical records.

And in any case where she expressed any ambivalence about whether the person was there primarily from a mental disorder versus a physical disorder, we did not count that persons [sic] as mentally disordered.

Q. As an example of the kind that you might have excluded after consultation with the director of nursing, what kinds of cases would they include?

A. I think one example would be somebody with either no prior psychiatric history and hospitalizations, or somebody with a couple of acute non-chronic psychiatric problems— say one or two admissions for acute psychosis or depression that had been treated a number of years before with no intervening history of mental illness, but then five years prior to then—1979—they developed a series of strokes and were exhibiting some of the symptoms of organic brain disease.

We would not call that person mentally ill.

[315] Q. Now after you—oh, by the way, what—in going through the medical records on the fourth floor, did you determine, or were you able to determine, anything about the quality of the records and the quality of records in general at the facility?

A. Our procedure on the first 52 was to look at really all the elements in the medical record, including things like a discharge summary from hospitals, other nursing homes, the state psychiatric hospital from where the patient might have come, report from the person's private physician if

they were admitted directly from home or from some other community facility.

The list of admitting diagnoses, the physician's orders, the medication sheets, the nursing notes—We found nursing notes very helpful in terms of what kind of treatment and what kind of services the person needed, and what they were being provided, especially in cases of mixed or multiple diagnoses.

We read the physician's admitting medical examination, the initial write up and virtually all aspects of the medical chart.

[316] We also did observe and talk to patients and talk to other staff regarding patients other than the director of nursing.

Q. Did you compare the medical records with any other records to determine the accuracy of the facility records?

A. In my opinion, they were very excellent medical records. They were complete. They were up to date. They were legible—even some of the physicians' handwriting was mostly legible.

Q. Now, after that process—well, were there records that the facility maintained which were derived from the medical records?

A. Yes. The facility had a log of all patients.

Q. A patient log?

A. A patient log.

Q. Did you test the accuracy of the patient log?

A. Yes, we went to the patient log on the first 52 patients and determined that the log very responsibly captured the one, two, three, four diagnoses—the relevant diagnoses—the ones relevant to the patient's placement. Then we subsequently used the log as an initial screen for all other patients that had been there since 1977.

[317] And we began by automatically excluding all patients who were in the log who had only a diagnosis of physical disorder, and automatically excluding all those that only had a diagnosis of mental retardation.

Q. Can we back up just a moment? When you say that the patient logs were accurate in relationship to the medical records to the extent that you tested that, can you give us an idea of whether or not the patient logs listed one diagnosis, or more than one diagnosis and then to that degree whether or not they reflected accurately what the medical records had?

A. I felt they reflected accurately what was—what the patient was being treated or cared for that was significant. I didn't feel the logs excluded any mention of any disorder for which the person was being actively treated to the degree that that was the significant reason why they had to be placed at that intermediate care facility.

Q. Now, when you used the patient logs, did you determine whether or not there were cases that were clearly excluded or included in the category of mental disease?

A. Yes. I repeat. We automatically excluded the people with primary or single diagnoses of mental retardation, and people with one or more diagnosis of physical disorders only.

[318] We automatically included people who had primary or only had diagnoses of mental disorders—and when I say mental disorder, I mean we automatically included only those people with mental disorders like schizophrenia, manic depressive illness, personality disorder.

We did not automatically include people with diagnoses among which included organic brain syndrome, chronic brain syndrone [sic], senility or alcoholism.

Q. Can you tell us whether or not the director of nursing was familiar with what you were doing—that is, as you were doing it, or at some point?

A. She was very familiar and helpful and worked with us the whole time. She retrived [sic] the charts as we asked for them.

Q. Did she make any indication concerning the kinds of diagnoses you were gleaning or classifications you were making?

A. No, only when we asked her.

Q. When you asked her?

A. When we asked her—this is how we have decided on this one, do you think we need to go see the patient, what is your view? This way or that way?

Q. So it was your view that there were some number of clear cases—that is, cases where there was little question?

[319] A. Absolutely. On the basis of the first 52—when we looked at all 52 records, and toured that floor, we were comfortable that we could include and exclude as I have just described.

Q. Now, after you went through the process of including or excluding the patients with the clear diagnoses, what did you do?

A. We looked at all other records—some over 200, I believe—that had mixed or multiple diagnoses. And all those that had diagnoses of alcoholism or organic brain syndrone [sic].

Q. You are referring to the medical records?

A. Medical records, yes. Then we went through each of those in as much detail as we felt we had to to make a decision as to whether the person's reason for placement there was primarily for purposes of a mental condition or disorder or set of symptoms as opposed to a physical disorder or condition or set of symptoms.

Q. Now, when you encountered diagnoses like alcoholism or organic brain syndrome or chronic brain syndrome, how did you handle those? Were they clear cases?

A. Most of them ended up being when you went through the chart in some detail. For example, if a person had been in a state psychiatric hospital for 10 or 20 years, and had a diagnosis of organic brain syndrome, and the feeling from the discharge summary from that state psychiatric hospital was that the person's—the reasons for the person's placement in a state psychiatric hospital as opposed to some other hospital or facility were the behavioral intellectual, emotional and self care problems that attend some people with organic brain syndrome, and these were the primary reasons why they needed to be in a place that provided psychiatric care—

[320] And then if that person had no other physical problems that by themselves would have necessitated the person's placement in an ICF environment as restricted as Middletown Haven is, I then called that person mentally ill.

Q. You are saying—let me see if I understand—If you ran across a diagnosis like alcoholism or organic brain syndrome or those in particular, did you automatically included them in one category or another just on the basis of the single entry or diagnosis?

A. No. We looked at the chart in as much depth as we felt we had to. And [sic] example would be somebody who, for instance, would have a diagnosis at the time we looked at the chart of residual schizophrenia and some other disorders diabetes, high blood pressure—

[321] If that person had also been in a state mental hospital for a number of years and had been there and been treated for the psychiatric symptoms of schizophrenia, and if the nursing notes and the admission work up indicated that there was some residual impairment of mental status in terms of that person's ability to care for himself, make judgments—

And if those impairments resulting from residual or from burning out or burnt out schizophrenia were the major

reason for the person's needing that restricted environment, I called the person mentally ill.

Q. That raises another question. For patients—all patients indicating a history of prior psychiatric hospitalization, did you automatically categorize them either way?

A. No.

Q. What did you do?

A. If they had only on the facility's log—only an admitting diagnosis of schizophrenia, personality disorder, paranoia and so on, and they also had a long history of state psychiatric hospitalization, and had come directly from the state psychiatric hospital, then we did automatically include those people.

I can say for people with the chronic mental disorder—the history of it—and who had some physical problems also—I mentioned diabetes, high blood pressure—uninary [sic] tract infections or chronic obstructive pulmonary disease—I did satisfy myself that the reason—that the physical problems alone would not have necessiated their placement in Middletown Haven Rest Home.

[322] If they only had the physical problems and not the residual schizophrenia or the personality disorder, the behavior disorder, they wouldn't have had to be there, they could have probably been at home or in some other facility and be taken care of by a visiting nurse.

I satisfied myself that there were no ongoing mental problems—[witness corrects himself] physical problems, that were contributing to the person's impaired mental status. If there was kidney failure or liver failure, the facility was quite good enough to know that through periodic laboratory inspections and the quality of nursing care.

The persons who was [sic] being impaired mentally for some new physical reason would not have been appropriately placed. They would have needed at least a SNC level of care of perhaps a hospital.

Q. Did you say that you had observed some patients?

A. Yes.

Q. Did you use some kind of criteria to determine when you needed to do that?

[323] A. I did not a formal mental status examination on any patient. [sic] I talked to some of them to satisfy myself that there was—by observing them—some obvious behavior or mental impairment that was ongoing and that probably was a reason—if I excluded any physical from the review of the chart—probably the major reason why they needed that level of care or treatment in that kind of restricted environment.

Q. You mean in cases where you felt the record wasn't clear or where you couldn't make a determination—

A. Or, again, to just double check myself that the records were credible. I felt the records in general were very, very credible with respect to my ability to understand what had gone on with the patient and what was going on with the patient now.

I never would use a record as the basis for my treating a patient myself. I would obviously examine him. But for purposes of understanding what was going on with the patient, I felt there was a high degree of credibility in the records.

Q. Now, you indicated, I think—well, I think you indicated that persons having mental disease can also develop physical problems? Can you describe that process

• • •

[325] But from an administrative point of view, from what I saw in Middletown Haven Rest Home in Connecticut, it is absolutely essential for the protection of patient care to make some distinction, especially in the younger age group, which the population of Middletown represented.

That people be placed in SNC and ICFs who have primary or secondary—who have some ongoing mental problem—receive not just care, but some active treatment. And I have no assurance—I know that that is not happening in a number of other nursing homes in Connecticut.

Prospect Gardens was mentioned as one of the six into which a large number of patients from state psychiatric hospitals were placed. I am in the process of terminating that nursing home. It is no question in my mind—I hope I don't because I hope there is a change in ownership—

There is no question in my mind that those patients placed in Prospect Gardens received actually better care for both their medical and mental and physical problems in a state psychiatric hospital than they have at the Prospect Gardens Nursing Home.

Q. What about Middletown?

A. At least from an administrative point of view, there needs to be some protection so we have assurance that people with whatever residual or primary mental illness placed in these facilities are getting the treatment.

[326] They were beginning to at Middletown Haven Rest Home. It was an excellent facility. They were clearly getting better care than they would have had in the state psychiatric hospitals. I wish they were all like Middletown Haven.

Q. Another category that might be considered difficult—what did you do when you ran across a case of cerebral vascular accident? Were they counted automatically as one or the other?

A. If there was no other psychiatric history or diagnosis, they were automatically called physical.

Q. They were called as having no mental illness?

A. They were called as being physically ill even though they may exhibit some of the same behavior patterns as

other people I called mentally ill in the institution. In that sense I felt we were quite conservative in our approach by not automatically excluding everybody who would have been called mentally ill because they had a major diagnosis that fell into ICD-9 or DMS-3 in the mentally disordered category.

For some of the same reasons, both conservative with respect to making the determination for this case, and also conservative for some of the reasons Dr. Taylor mentioned yesterday of not wishing to label people unfairly.

[327] Q. Well, when you say conservative in terms of your—could you compare your approach in the way you handled cases like alcoholism and organic brain syndrome and the standards in the ICD or the DSM?

A. I feel quite comfortable with how we approached these decisions, considering how they are both labeled in those two diagnostic standards of criteria, and also for purposes of counting up numbers of people in one category or another, which we unfortunately had to do for purposes—the larger purposes of assuring that Connecticut provides active treatment for these people if they are placed in long term care facilities.

Q. Now, the results of your review were described in the official report?

A. Yes. Attachment F. I might also say with respect to the two categories of people with alcoholism and organic brain syndrome, that on the basis of just pure numbers alone, we automatically excluded people with those diagnoses, the facility would still have been over 50 percent with mentally ill from other categories.

Q. So as reflected in the report, based on the kind of evaluation you made, the overwhelming majority of patients were—

[328] A. Both by virtue of numbers and by virtue of the overall character of the facility—the way the staff talked

about the kinds of treatment they provided, the kinds of facility they felt they were—and they were proud of it—and with a great deal of deserve.

The character of the consulting medical staff and the kinds of therapies or care that were going on—group therapy—the consulting psychiatrists—And I might say the group therapy was ordered by the physicians as an integral part of an active treatment program.

They might have had certain behavioral—goals for behavioral change, certain kinds of psychotropic medicines, but that is not necessary for counting something as active or responsible treatment for somebody with mental symptoms. Programs to do with the community and do part time work in a sheltered workshop was one—the sheltered workshop equivalent, I should say, on the main street of Middletown with some of the local commercial operations there that were being responsive to the needs of the patients.

And it was one—all these various parts merged together were integrated as a part of the treatment program, ordered and signed by the psychiatrists.

Q. Now, aside from the fact that you found—that is that you made a determination about the number of patients or the percentage of patients having mental disease in the facility, did you make any other observations or discuss any other matters while you were there in terms of the facility.

[329] A. Well, it was clear to me as a general impression that it was overwhelmingly and beyond any reasonable doubt for many, many reasons—mostly from the character of the medical records and my observations—discussion with staff and observations of patients. It was very primarily an institution for mental disease.

And they were beginning to provide the kinds of treatment that the character of their population required, and

that was very heartening. I was very pleased yesterday to hear that subsequently Connecticut calls it an institution for mental disease and has expanded the treatment such that—and I think it is very telling that their recidivism rate back to the state hospital has almost gone down to zero.

That tells you the kind of people in that institution were the kind that could both through treatment, not move backwards lot a lot of them were ready to move forward. In my judgment, about half the people in Middletown Rest Haven when I saw it could have been placed in other even less restricted environments.

And I only said that they were appropriately placed because Connecticut doesn't have the other kinds of facilities available to them.

[330] Q. Now, I guess because of the way the law is written in terms of covered services, there is an issue in the case about whether it is proper to focus on diagnoses of individual patients or whether it is necessary to focus on the facilities' services—the kinds of care and treatment available and given to the patients.

Do you feel that there is any relationship between diagnosis and services?

A. I certainly do. I feel there should be if there is not. I felt there was at this facility. However, we did not just focus on diagnosis. We did look at the evidence in the medical record and also by observing the facility—what kinds of services were being provided.

Q. Now, if a facility were not concerned with diagnosis, could it provide the kind of care that the patients need?

A. Certainly the answer to that is, No—certainly for the population of patients that I saw at Middletown Haven Rest Home. It might be argued that if diagnosis isn't important, the services probably aren't medical in character.

If diagnosis isn't a part of the spectrum of an evaluation—diagnosis and treatment, it might be argued that the facility is being—the services being provided were pure care of a social maintenance nature and not medical.

[331] Q. We have had a lot of discussion about the meaning of diagnosis. Now, would you say the federal review team—not necessarily yours, but any one—would actually be diagnosing patients or are they doing something else?

A. Hopefully they would not pretend to diagnose by looking at the piece of paper. I think you have to differentiate between being able to understand—have enough credibility in the medical record—to understand what is going on from it versus you, yourself treating.

I don't think non-medical or non-nursing auditors would be able to have necessarily the same kind of credibility that I was able to have concerning the medical records. But if you assume that they are accurate and of reasonable quality, they do give you, I think, an accurate understanding of what is being treated.

And I think you can make a judgment as to what the primary reason for the person's being placed there is in terms of physical impairments versus mental impairments, yet leaving the issue aside as to what caused the mental impairment.

Q. So when you classify patients, or when any team would classify patients, as either mentally ill or not, you are taking into account more than just diagnosis? You are saying also—

[332] A. We certainly did.

Q. Yes. What kinds of factors—

A. Everything in the medical record—things pertaining to the services actually being given and evidence in the chart of—

Q. So there is a difference between the concept of—at least as it could be understood—the concept of making a diagnosis and your determination of whether or not someone is mentally ill?

In other words, to make the diagnosis—well, let's put it this way. I guess the record contains diagnoses, but when you make your decision to classify someone as mentally ill, you do more than just look at the diagnosis?

A. I did not exclusively look at the diagnosis except in those cases where on the basis of the law, and the validity check that I did on the law—I included/excluded those categories that I previously discussed.

Q. Were you concerned with the kind of treatment or the reasons for having the person in the facility?

A. Absolutely.

Q. And that is part of the classification process?

A. It was for us.

[333] Q. There has also been some discussion about—as I understand it—a distinction between a psychiatric disorder and a neurological disorder. Is it really one or the other? That is, taking cases of neurological disorder, would you consider all or some of those patients having these—having neurological disorder—as being mentally ill or having mental disease?

A. Well, I did again in, for instance, the case of the long-standing organic brain syndrome problem that had been treated for years and years in a state psychiatric hospital. As was mentioned yesterday, those problems have to do with the actual loss of brain cell tissue through a number of different processes. Just aging is one.

Q. What happens to treatment—

A. Well, there is no treatment. We have not learned

yet how to regenerate brain cells, and so the actual treatment for the cause of that—that neurological condition—doesn't exist unfortunately for many sub-types of organic brain disease.

However, when the symptoms are—when the symptoms are primarily psychiatric because of the emotional judgment, intellectual, behavioral components of them—I call the person mentally ill by virtue of what he exhibited that needed to be treated, on the one hand, and what the facility was providing him on the other—providing him through the use of psychiatrists, as opposed to neurologists.

[334] There was no consulting neurologist on the staff at Middletown Haven Rest Home, although I am sure that when neurological services had been needed, they would have been sought in local hospitals—private practice groups.

Q. Now, another issue—well, I should say an argument that Connecticut has made is that Middletown Haven rendered the types of services that are provided by a typical ICF. Do you agree with that or disagree?

A. I would like to think that the range of services and the staffing pattern—the quality and quantity that they had—represented a typical ICF. I know that is not true in New England. Because there are a lot of mentally ill—well, they are only 10 percent or 15 percent—those patients, if they are there, need some treatment.

Our regulations have trouble going after those kinds of problems, given our current set of regulations. Middletown Rest Haven, I felt, was functioning essentially as an ICFMH, which doesn't exist. It is not recognized, but they exist de facto, and the 50 percent rule—again I don't care if there are five percent people that need some specialized treatment—they should be getting it.

ICFMH equivalent to the ICFMR—We had a handle

• • •

[343] But the mental condition—the mental impairment—the behavioral problem did.

CHAIRMAN SETTLE: May I just ask a question about that? Some of the states have pointed out that a person like that might need some support—some passive care, but might not need to intensity of services that one would normally associate with a state mental hospital.

Do you find that to be the case based on the document you have in front of you?

THE WITNESS: I would think so, but with the caveat that I think this person needed the kind of active psychiatric treatment he was getting here through the program. Passive—I don't associate myself with passive care. I don't think this person had been given up on. I think the reason why he was placed there was that he probably got even more active treatment there than he would have at the psychiatric hospital.

And he was a potential candidate to move even to a less restricted environment after being treated in this ICF. I can't absolutely, certainly answer your question because I don't have his whole medical record in front of me to go through and refresh exactly what I did in this case.

But I can give you an idea of why, I think, I made some of the decisions I did.

• • •

[348] such a facility be certified for participation in the Medicaid program?

A. Again, if we were all clear on the exact definitions of what we meant by those things, I would say, No, it would not be.

Q. You mentioned that you talked with the staff at the facility at Middletown Haven. Can you tell me how the staff characterized the facility?

A. They felt that they specialized in treatment of people with primarily mental disorders. They specialized in it. The facility was primarily geared to it. They hired staff with that kind of background and interests, and they were proud of it.

And I say, deservedly so.

MR. ENG: No further questions.

CHAIRMAN SETTLE: Mr. Miller?

CROSS EXAMINATION

BY MR. MILLER:

Q. Dr. Osborne, from your last answer and a number of other comments, I have the impression that you have a high opinion of Middletown Haven, at least as of the time that you visited it?

A. Comparatively, yes, I would say a high rating compared to other ICFs that were treating people with these kinds of conditions.

[349] Q. In Connecticut or throughout New England?

A. Throughout, but also in Connecticut.

Q. You were asked a question by Mr. Eng that I didn't quite understand your response. He asked you if this Middletown Haven at the time you visited it, was like a typical ICF, and I am not quite sure of your answer to that questions.

Could you tell me what—

A. I equivocated. I didn't equivocate—I think it is more complicated than that. I would say it was typical of what an ideal ICF that has some mentally disturbed patients should have. Far too many of them don't. So, it is typical of what the ideal should be under the current law.

It is not typical of—especially many others in Connecticut with respect to its staffing pattern. I would say that it

is sort of on its way to becoming something that it isn't now through some of the additional staffing changes and programming changes they have taken when they decided they wanted to become an IMD.

Q. I want to come to that in a second, but at the moment I just [sic] focusing on what it was at the time you visited it, and I think what you said was that it was among the better ICFs in your experience. Right?

[350] A. Absolutely.

Q. In your review of the facility, you—did you or did you not go to Middletown Haven with the view toward reviewing the type of services which were provided?

A. Yes, we did.

Q. You gave some discussion about that this morning. Could you—are you in a position, based on your review there, to summarize the type of services provided the patient population at Middletown Haven?

A. I think so.

Q. I would appreciate it if you could.

A. There were all manner of nursing services appropriate for an ICF. That was all there. On the service side, I would characterize it as responsive to the mentally ill. There were both direct and indirect services—direct services in terms of qualified staff counselling with patients on behavior problems, patient groups being run, activities designed for patients.

I saw one group of relatively young people going out for an activity in the community together. There was design for part of their treatment program. Indirect services in the sense that psychiatrists both for in-service staff education and for enhancing quality of care of patients were having regular group sessions with staff on the various wards.

[351] An additional reason for that is to [sic] that they were concerned with building a mileau [sic]—

Q. Just a minute. The staff was having group sessions with the medical staff, is that what you said?

A. Yes. Consulting psychiatrists were spending some time with staff in troups [sic].

Q. Thank you. I didn't mean to interrupt you.

A. Another purpose for that is that a team working together on a ward can function, and functioning as a team, can deal with some behavior problems, and that is very characteristic of an IMD—a programming method—on the way toward mileau [sic] therapy.

Q. Incidentally, these psychiatrists that you refer to—the three consulting psychiatrists—do you happen to know the amount of time they spent at the time at Middletown Haven?

A. My impression was that it was too little for the problems the population had, but I was quite tickled to see there was any at all.

Q. Would you think about one day a week would have been approximately what they were doing?

A. I can't recall. I think it was something like a week apiece, but I can't swear to it. My impression was it was too little for the patients' needs, but it was far more than was being provided for that kind of patient in many other ICFs, and I was pleased with that.

[352] Q. If you had an ICF that focused on the treatment of people with say cerebral palsy, is that a ridiculous assemption [sic] or could there be such a facility?

A. I think that is relatively ridiculous. Cerebral palsy is a wide range of those mental, psychiatric, neurological and physical conditions.

Q. How about epelepsy [sic]?

A. My feeling is that is awful ridiculous and that it would not make sense to "concentrate" with the word used yesterday, those people because there is not a special need.

Q. I am looking for some condition that would warrant some specialized treatment. You could pick an example of your own. How about people with heart conditions or perhaps people who are not ambulatory?

A. I wouldn't say so. I would rather group people regardless of diagnostic categories—based on their need, and if their needs, however, rather similar in terms of needs for psychiatric programming—whether they are cerebral palsy or whether they have organic brain syndrome, I think the advantages of some concentration for the quality

• • •

[361] being provided. I didn't see anything in the audit report that discussed the services at Middletown Haven provided. I may have overlooked that.

Q. Are you familiar with the audit report?

A. Yes, I am.

Q. The portions that I read at all—I saw the discussion of the patient characteristics, but I do not recall any discussion of the services being provided to them. Do you know why that was omitted from the report?

A. Well, in our methodology, I think it is explicit that we looked over some 200 charts of all patients that we had any questions about, and in looking at a chart in depth and all the various items and information I mentioned earlier, what you are looking for is the services.

Doctors' orders, medication records, nursing notes—the medical record is a record of, obviously, not just the diagnosis, but also the ongoing record of services provided to that patient and documentation of the patient's response to those services.

Q. One of the criteria discussed in the audit report was the age breakdown of the population at Middletown Haven compared to other ICFs. You haven't testified on that this morning, but are you familiar with that aspect of the report?

• • •

[370] Q. Can they?

A. They can, and I think probably some do. I would say I don't think they do it in the integrated fashion of a complete treatment program targeted for an individual person with a psychiatric oversight, as was occurring in Middletown Haven.

MR. SEIPLE: No further quesitions.

CHAIRMAN SETTLE: Let me ask a question of Mr. Eng, or perhaps you know. In the other three states, were those reviews conducted with the assistance of psychiatrist, or is it only Connecticut that we have a psychiatrist involved?

MS. HATHAWAY: It is my belief that only Connecticut had a psychiatrist. California had an audit team, and I believe in all the remaining states, it was Medicaid audit teams that did the work.

CHAIRMAN SETTLE: Mr. Miller, do you want to ask more quesitions, or shall I go to another state?

MR. MILLER: I don't think I have any more.

CHAIRMAN SETTLE: All right. Minnesota—Mr. Held?

MR. HELD: Yes. Perhaps I could just sit up here?

CHAIRMAN SETTLE: Sure.

• • •

[401] an ICF if it merely provided custodial care. Is that correct?

A. Well, that is first and foremost my professional opinion. I would go back and read the regulations and have my attorney and me debate as to exactly whether the regulations require that or not. For the kinds of people I saw Middletown Haven, it would be dangerous and abhorent if anything less that medical treatment, some active treatment—

Q. I was wondering if you could take a few minutes to describe the type of treatment that you found at Middletown Haven and what you would ordinarily expect to find at at [sic] ICF that was not an IMD.

A. I don't think that the typical ICF in New England you would find any psychiatrists, even in the consulting capacity. Usually you wouldn't, I think. You would find other categories of medical doctors. You would not find staff trained or interested in copeing [sic] with the problems of the mentally ill.

You would not find psychiatrists aside from their actually seeing and treating patients, you would not find them running groups or nursing—groups of nurses on individual wards. You would not find psychiatrists engaged in one to one psychotherapy or one to one re-evaluation of patients.

[402] You would not find the kind of patient therapy groups that my understanding is were going on at Middletown Haven or just about to—planned because of the recognized need. And I don't think in—this is to a lesser extent—you would find the kind of recreational activity program targeted to groups of patients with similar kinds of growth potential and needs that you found at Middletown Haven.

I am sure you do find some of that at other ICFs. I don't know first hand. Those are some of the things that I think—and I think what you would find maybe overly active treatment in the use and sometimes the abuse of psychotropic medicines in other ICFs, which was happily absent at Middletown Haven.

Q. If you can also briefly talk about the services that you would expect a state mental hospital to provide as compared to what you found at Middletown Haven.

A. It is hard to answer that one because there is now a very wide range of capability—the ability to actively treat in state psychiatric hospitals. If there is an industry norm, I would be hard pressed to say what it is.

Q. Would there be anything that you could point to that might distinguish the services or the treatment of Middletown Haven from those provided by a state mental hospital?

[403] A. Well, the old typical and hopefully fast-fading from the scene image of the state psychiatric hospital, I frankly would not find much more than you would find at Middletown Haven. I can't speak for the three, four, five whatever it was psychiatric hospitals in Connecticut personally.

My impression is that there has been some considerable movement in their capability to treat—improvement—but I really couldn't answer that piece.

Ms. FORD: Thank you.

THE WITNESS: As I pointed out in the attachment, I think in some ways an ICF like Middletown is a more restricted environment than a state hospital in that you don't have the gynmasiums and the pool halls and the floating lawns and the multiple building and so forth.

But on the other hand, I think there you could argue that there probably is more active treatment that is appropriate to patients' needs.

Ms. FORD: Thank you very much.

MR. KAUFMAN: What is your opinion of the agency's criteria for identifying ICDs?

THE WITNESS: Well, as I use them or modified them I think they are adequate anough to do what I think is very

important—mainly to be able if not for patient needs, for administrative needs to say is this facility providing the services that the population it serves has.

[404] And we need some assurance about that. And in the absence of better regulations, which may mean fewer regulations and more people who can go out and take a look, I think it is awfully important to use that IMD concept because it is one handle we have on situations like Prospect Gardens in Connecticut.

MR. KAUFMAN: It sounded to me like you did significantly modify them in your own approach. Am I correct?

THE WITNESS: Which ones are you referring to?

MR. KAUFMAN: Of the eight that were listed—The list is at the bottom of page 13—

THE WITNESS: I think I was answering—thinking you were asking me about the criteria for actually looking at individual patients to say whether they were or were not—which is on this letter from SRS Regional Commissioner of the ABCD.

But in answer to the question about the 10—I think taken in aggregate, with the kind of review at Middletown Haven, I think they are adequate. I would be happy, I think, to do a little more thinking about that and give you a fuller maybe more thoughtful response than I could. . . .

APPENDIX D

FY-76-44

DEPARTMENT OF HEALTH,
EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE
WASHINGTON, D.C. 20201

November 7, 1975 MEDICAL SERVICES
ADMINISTRATION

INSTRUCTION—PS

TO: SRS Regional Commissioners

SUBJECT: *FIELD STAFF INFORMATION AND INSTRUCTION SERIES:* FY-76-44 Federal Financial Participation in Payments for Care in Institutions for Mental Diseases

As you know, Federal matching under Medicaid is available under certain conditions at State option for payments for inpatient hospital services, skilled nursing facility services and intermediate care facility services for individuals 65 years of age or over in an institution for mental diseases and for inpatient psychiatric hospital services for individuals under 21. Otherwise Federal matching is expressly excluded by the Social Security Act from any payment for care or services provided to individuals in institutions for mental diseases. It has come to our attention through recent Regional Office findings and a GAO study by the Mental Health Task Force that this has been ignored, that Medicaid payments have been made for individuals between 21 and 65 in institutions for mental diseases and that Federal financial participation has been claimed improperly. To the extent that this has been or is being done there is a serious potential for sizeable audit exceptions.

The pertinent regulations are contained in 45 CFR 248.60, and 45 CFR 249.10(c)(1). The character rather than the licensure status of the institution is of paramount importance.

The excluded institutions are those "primarily" providing care for patients with "mental diseases." An institution is characterized as "primarily" one for mental diseases if it is licensed as such, if it advertises as such or if more than 50 percent of the patients are in fact patients with mental disease. In some instances a facility may be "primarily" concerned with such individuals because they concentrate on managing patients with behavior or functional disorders and are used largely as an alternative care facility for mental hospitals, even if less than 50 percent of the patients have actually been diagnosed as having a mental disease. Mental diseases are those listed under the heading of mental disorders in the eighth revision, International Classification of Diseases, Adapted for Use in the United States (ICDA-8 Public Health Service Publication Number 1693), except that mental retardation is not included for this purpose. The underlying cause of the mental disease is irrelevant. Although many individuals suffer from a combination of mental and physical disorders there is usually no problem in discerning which is responsible for the need for institutional care.

The situation in each State will affect the complexity of identifying those SNF's and ICF's maintained primarily for patients with mental diseases. When they are separately licensed or are under the jurisdiction of the mental health authority, it should be relatively easy. However, when such facilities are not easily distinguishable, a major effort may be needed to identify them and to determine whether Medicaid reimbursement is proper and is limited to individuals 65 and over. Those facilities which are frequently or predominantly used for individuals who are either discharged from mental hospitals or would otherwise be admitted to them are almost certainly in this category but others would also be in this category.

In order to determine whether there is a serious potential problem and what additional steps or resources will be

necessary we are requesting that the attached form be completed for each State in your region. We are focusing attention at this time on SNF's and ICF's as we assume, absent evidence to the contrary, that improper claims related to age are not a problem for care in psychiatric hospitals. Other aspects of the requirements related to psychiatric hospitals will receive attention subsequently.

In addition to the form we would like your overall regional assessment of the scope of any problem, the need for in-depth reviews and steps and man-power necessary to carry them out. Please forward your reports to Mrs. Emily Nichols, Chief, Health Services Branch, Division of Policy and Standards, Room 4513, Switzer Building by January 1, 1976.

/s/ M. KEITH WEIKEL
Commissioner

Attachment
Cleared by OFO
Expiration Date: January 1, 1976

DECEMBER 1975

**COMPLIANCE WITH 45 CFR 249.10(c)(1)
AND 45 CFR 248.60**

STATE: _____

1. In your opinion has the State been aware of and taken action to assure compliance with 45 CFR 248.60 and 249.10(c)(1)?
Yes _____ No _____ Don't know ____

2. Has the State taken steps to identify skilled nursing and intermediate care facilities established and maintained primarily for the care and treatment of patients with mental diseases?
Yes _____ No _____ Don't know ____

3. If yes, describe them.

4. Do you consider them adequate?
Yes _____ No _____ Don't know ____

5. Are these mental health facilities subject to special State licensure standards or requirements?
Yes _____ No _____

6. If yes, describe them.

7. Does the State have controls to assure that psychiatric hospital claims are limited to individuals over 65 and under 22?
Yes _____ No _____ Don't know ____

8. If any answer above is either "no" or "don't know" discuss your recommendations for State or Regional action.

9. Describe any measures the Region has taken to monitor compliance with these Regulations.

10. Further comments:

FY-76-97

DEPARTMENT OF HEALTH,
EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE
WASHINGTON, D.C. 20201

May 3, 1976

MEDICAL SERVICES
ADMINISTRATION

INFORMATION – PS
URGENT

TO: All SRS Regional Commissioners

SUBJECT: *FIELD STAFF INFORMATION AND INSTRUCTION SERIES:* FY 76-97 Institutions for Mental Diseases: Possible Compliance Issues

The varied responses to FSIIS: FY-76-44, November 7, on "Federal Financial Participation in Payments for Care in Institutions for Mental Diseases," have not allayed our concerns regarding payments to institutions for mental diseases but have heightened our awareness of *great discrepancy in the understanding, interpretation and implementation of policy.* FSIIS FY-76-44 had two main purposes:

1) to get overall *Regional* assessments of problems or potential problems concerning States' adherence to 45 CFR 249.10(c)(1), limitation on Federal financial participation in institutions for mental diseases and

2) to solicit your support in the Department's endeavor to assure States' compliance with all Federal requirements governing payment for care in institutions for mental diseases.

The responses were very uneven and a number did not give a Regional assessment. Some of the answers which gave us concern indicated: (1) that the questionnaire was xeroxed, sent to States and upon return forwarded to Central Office without Regional assessment; (2) that the overall instructions and information in the FSIIS were

misunderstood; (3) that the institutions examined closely were primarily those on the grounds of or connected in some way with mental institutions, not freestanding SNF's or ICFs that "may" be mental institutions; (4) that as the States monitor payments to psychiatric institutions, SNFs and ICFs which may be "institutions for mental disease," are not identified and monitored; (5) that in one State patients in SNFs limited to the mentally ill could be any age and payments would not be restricted to individuals 65 or over; and (6) that some regions are unable to devote time and attention required to provide adequate assessments as the subject of the FSIIS was not a priority item or Regional staff was not sufficient to perform such as task.

The policy regarding FFP in institutions for mental diseases (which may be SNFs and ICFs) is not new! The overall character of a facility has been a point for consideration since the enactment of the "Long Amendment" permitting Federal matching for individuals over 65 in institutions for mental diseases. There has clearly been recognition that some nursing homes and intermediate care facilities were in fact institutions for mental diseases because of the exclusion of these facilities from Federal matching in 1905(a)(4) and (15) of the Social Security Act and their introduction in 1905(a)(14). If institutions for "mental diseases" were only hospitals, these distinctions would not have been necessary.

Free-standing SNFs and ICFs may of themselves be "institutions for mental diseases." The definitions in 45 CFR 248.60 and 249.10(b)(14) lead to these conclusions:

(1) services for individuals 65 years of age or over in institutions for mental diseases specifically include skilled nursing and intermediate care facility services;

(2) "an institution for mental diseases is one primarily engaged in providing diagnosis, treatment or care of persons with mental diseases."

From information received and reviewed over the past months and recent GAO findings, we know that incorrect reimbursements are being made for individuals between 21 and 65 in institutions that are for mental diseases. This situation warrants our attention in terms of State compliance with an eye toward recouping Federal funds at a later date. This was emphasized at the recent meeting with the Associate Regional Commissioners.

Further, it was discussed in some detail by Dr. Willging at the Belmont Conference in March as one of the major priorities of the Medical Services Administration.

It is of utmost importance that Regions begin to assess or continue to assess the situation as it exists now in order to assist States where necessary in complying with applicable Federal Regulations. Our staff is ready to help you with any specific problems or questions and has already been following up on some specific concerns.

/s/ PAUL R. WILLGING
for Commission, MSA

Expiration Date: None

FY-76-156

DEPARTMENT OF HEALTH,
EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE
WASHINGTON, D.C. 20201

September 14, 1976 MEDICAL SERVICES ADMINISTRATION

INFORMATION—PS

TO: SRS Regional Commissioners

SUBJECT: *FIELD STAFF INFORMATION AND INSTRUCTION SERIES:* FY-76-156 Mental Health Under Title XIX

This is to bring you up to date on activities in regard to the mental health aspects of the Medicaid program.

1. We have continued to review and consider the GAO draft report on deinstitutionalization and will be moving to incorporate as many of the recommendations as possible in our current and future work plans. The report emphasizes the need for intradepartmental cooperation and coordination, with which we heartily concur. We recommended such cooperation on a Regional basis to the ARCs and suggested additional discussions with their ADAMHA counterparts. We are attaching a list of that Regional staff.

Although we recognize that both ADAMHA and SRS staff already have heavy priorities and fixed work plans, we nevertheless believe that time spent in discussion or identification of mutual problems or of special competencies or interests can be both helpful and rewarding. We are therefore recommending for your consideration the establishment of a committee similar to one which has been functioning in Washington for several years. It brings together representatives from the various health, Social Security and SRS agencies concerned with mental health programs for discussion of mutual interests and program developments. Recent visits by Central Office staff to

Regional Offices indicate to us the value which might accrue to greater inter-disciplinary and inter-agency exchange and consultation.

2. There continues to be confusion as to whether patients *who no longer need active inpatient hospital psychiatric treatment* and are discharged to a community-based facility, particularly a SNF or ICF, are to be considered patients with mental disease. When such individuals cannot be discharged to independent living or when they are on conditional release status, *they continue to be primarily patients with* mental disease. The spell of mental illness has not been broken and the development of other concurrent or independent physical problems does not affect this. *Patients with mental disease may even develop major physical problems which do* not change their primary disability. *The function of a mental hospital is to provide active psychiatric treatment of patients with mental problems. A SNF or ICF is not a substitute for a hospital but should be used to provide management/treatment/rehabilitation/a controlled environment and/or other care for patients not needing active psychiatric treatment.* The disease may be in remission, in a period of inactivity or at a chronic stage which requires primarily careful management and observation by professionally supervised mental health staff.

3. We are pleased to note that there has been widespread progress in the efforts to assure observation of the prohibition against Federal matching in institutions for mental disease for individuals under 65 (Reference: FSIIS 76-44 and 76-97). Various methods in addition to those discussed in earlier issuances have been suggested to help States identify suspect facilities, including proximity to State institutions (for example, within a 25-mile radius) and age distribution uncharacteristic of nursing home patients (i.e., a preponderance of individuals under 65). Also, included in these methods would be a determination as to

whether the basis of Medicaid eligibility of patients under 65 in suspect facilities was due to mental disability.

We feel that the steps outlined by Region IV over a six-month period have merit and are summarizing them for the benefit of other Regional Offices: issuance of Regional memoranda to States, answering questions and clarifying policy; discussions with personnel of various agencies within each State; identification through the State Medicaid agencies of suspect facilities; and instructions to the States about steps to be taken to actually determine the character of these facilities—i.e., whether they are institutions for mental diseases. They recommend the use of review teams (constituted in accordance with 45 CFR 250.23(a)(2)(i) or 250.24(a)(2)(i)(A)(C)(D) and (E) whichever is appropriate) to review patients in those facilities where the determination cannot be made without applying the 50 percent criterion. The teams would make a judgment about each patient as to the presence or absence of disability in functioning resulting from a mental disease and whether the mental disability resulted in the patient's need for skilled nursing or intermediate care. Patients would be classified as follows:

a. Patient with physical problem necessitating nursing home care who has no mental disability;

b. Patient with mental disability and physical problem, either of which would independently require nursing home care;

c. Patient with mental disability necessitating nursing home care who has no significant physical problem;

d. Patient with physical problem that would not independently necessitate nursing home care, but who has a mental disability that would preclude his proper handling of his physical problem outside a nursing home. Therefore, nursing home care is necessitated because of his mental disability in functioning.

Patient categories c and d are designated as mental patients for purposes of this determination, and should be included in the mental patient census. Special attention will be necessary for patients in category b, as discussed in 2 above, and it may not be possible to make the determination solely on the basis of an individual's current condition. Patients with long-standing mental disability develop major physical problems and vice versa. When it is clear that institutional care resulted from one or the other, the patient would be classified according to the original disability. In other instances, no such clear-cut distinction is possible and such patients would not be included in the mental patient census. While patient populations will change, administrative necessity would indicate that the status of a facility would not be changed without special request except at a designated time, such as renewal of provider agreement or at the time of the annual survey.

4. Questions have been raised about access to private patients' records when a count down by patients is necessary to determine whether the majority of patients are there for mental illness. When a private patient record review is not possible, the survey team will have to rely on other factors such as their professional observation, age of patients, discussion with staff of the overall character and nature of the patient's problems, specialties of the attending physicians, and sources of referral. A high percentage of private patients in a facility will tend to make the determination of its character more difficult. However, we believe a properly qualified team can make such a judgment.

5. We are considering further steps, including dissemination of some of this material directly to the State agencies and the formulation of interagency and interdisciplinary workshops. We will be glad to have suggestions and comments or to answer specific questions.

/s/ M. KEITH WEIKEL
Commissioner

Attachment

Expiration Date: None

APPENDIX E

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Care Financing Administration
Baltimore, Maryland 21235

CERTIFIED MAIL—RETURN RECEIPT REQUESTED

Mr. Edward W. Maher
Commissioner
Department of Income Maintenance
110 Bartholomew Avenue
Hartford, Connecticut 06106

RE: File No.
CT-80/01/028

Dear Mr. Maher:

By letter dated May 8, 1980, the Regional Medicaid Director forwarded to your agency the regional office report entitled "Review of Costs Claimed by the Connecticut Department of Income Maintenance for Services Provided to Title XIX Recipients Residing at Middletown Haven Rest Home, Middletown, Connecticut." The report covered the period January 1, 1977, through September 30, 1979. This letter is to convey our determination that payments to this facility totalling $1,634,655 in Federal financial participation (FFP) are unallowable.

Medicaid regulation 45 CFR 248.60(a)(2) [currently, 42 CFR 435.1008(a)(2)], which implements Section 1905(a)(17)(B) of the Social Security Act, provides that:

> "Federal financial participation . . . is not available in medical assistance for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases. . . ."

Section 1905(a)(vii)(14) and (16) of the act permits, at the option of the State agency, payment for:

> "(14) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases . . . (16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h)."

However, Connecticut has elected to exclude services to these mentally ill in institutions for mental diseases (IMDs) as a covered service under its title XIX program.

Regulations at 42 CFR 440.2(b) [formally [sic] 45 CFR 249.10(b)] state:

> "Except as limited in part 441, FFP is available in expenditures under the State plan for medical or remedial care and services as defined in this subpart."

Because FFP is not available in payments to IMDs for persons aged 21 to 64, and because the State plan does not cover services by such facilities to individuals under 21 or over 65, no payments to IMDs are eligible for FFP.

The regional office conducted a review of the Middletown Haven Rest Home in order to determine if the facility should be classified as an IMD. Regulations at 42 CFR 435.1009(e)(2) [formally [sic] 45 CFR 249(b)(14)(iv)] state in part:

> "'Institution for mental diseases' means an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases whether or not it is licensed as such."

Your May 30, 1980 letter to the Bureaus of Program Operations and Program Policy, Health Care Financing Administration, expressed concern that the regional office report did not focus on the type of care that the facility

provided, and concentrated on the characteristics or diagnoses of the patients. You also stated that the regional office, in making the IMD determination, did not focus on the care actually rendered but "solely on a diangosis of some of the residents."

Regulations at 42 CFR 435.1009(e)(2) indicate that any criteria used to make an IMD determination should focus on the patient population, not the services the patient receives. Whether a facility is an IMD should be determined by whether or not the overall character of the institution is that of one that provides care to mentally ill individuals.

The Department of Health, Education and Welfare developed criteria to determine what constitutes "primarily engaged" and the "overall character" of a facility under the meaning of the regulations. The criteria, which are consistent with the intent of the regulatory language, are contained in instructions issued by the Medical Services Administration (the predecessor organization to the Medicaid Bureau before reorganization into the Health Care Financing Administration). These are found in the *Field Staff Information and Instruction Series* (FSIIS) #76-44 dated November 7, 1975, 76-97 dated May 3, 1976, and 76-156 dated September 14, 1976.

The following criteria are detailed in the cited FSIIS and were utilized by the regional office in determining whether the Middletown Haven Rest Home met the "overall characteristics" of an IMD:

1. The facility is licensed as an IMD.
2. It is advertised as an IMD.
3. More than 50 percent of the patients have a diagnosis of mental disease as defined in the *International Classification of Diseases.*
4. The facility is used by mental hospitals for alternative care.

5. Mental patients from the community were admitted that may otherwise have entered a mental hospital.
6. The facility is in close proximity to a State mental hospital (a 25-mile radius).
7. The age distribution of a facility is uncharacteristic of nursing home patients (i.e., a preponderance of patients under age 65).
8. The basis of the Medicaid eligibility of patients under age 65 is due to mental disability.

In addition to these eight criteria, the regional office also considered two further factors in reaching their determination. These are:

9. The facility hires staff specialized in the care of the mentally ill.
10. Independent professional reviews conducted by State teams report a preponderance of mental patients in a facility.

The regional office evaluation of these criteria as they apply to the Middletown Haven Rest Home are detailed in pages 6-13 of the regional office report. Based on the results of the regional office review, the Middletown Haven Rest Home has been identified as an IMD.

Because payments for services to the mentally ill in an IMD are not eligible for FFP under the Connecticut State plan, I am disallowing $1,634,655 FFP. A detailed schedule of total expenditures submitted and FFP disallowed by quarter is as follows:

Quarter Ending	Total Expenditures	FFP
3/31/77	$ -0-	$ -0-
6/30/77	91,169	45,584
9/30/77	114,817	57,409
12/31/77	175,041	87,520
3/31/78	163,758	81,879
6/30/78	221,262	110,631
9/30/78	281,382	140,691
12/31/78	690,954	345,477
3/31/79	529,244	264,622
6/30/79	572,792	263,896
9/30/79	473,891	236,946
TOTAL DISALLOWANCE	$3,269,310	$1,634,655

This letter constitutes your notice of disallowance in the amount of $1,634,655 FFP. Please make a decreasing adjustment in that amount on line 10B of your next quarterly expenditure report (Form HCFA-64).

Under Section 1116(d) of the Social Security Act, you have the right to request reconsideration of this disallowance. If reconsideration is requested, your application must be submitted to the Executive Secretary, Departmental Grant Appeals Board, U.S. Department of Health and Human Services, Room 2004, Mary E. Switzer Building, 330 C Street, SW., Washington, D.C. 20201, no later than 30 days after the postmark date of this letter. Your application must clearly identify the question or questions in dispute and contain a full statement of your position with respect to such question or questions and the pertinent facts and reasons in support of such position. You must attach a copy of this letter to your application. Send a copy of your application to me and to the Regional Medicaid Director. Your application will be processed pursuant to the rules and regulations of the Departmental Grant Appeals Board which are currently found at 45 CFR part 16, as amended. See *Federal Register*, Vol. 43, No. 44, published March 6, 1978.

Should you require further details regarding this matter, please contact the Regional Medicaid Director at (617) 223-6881.

Sincerely,

/s/ PAUL WILLGING

Mildred L. Tyssowski
Director
Bureau of Program Operations

cc: Regional Medicaid Director, Region I
Regional Administrator, Region I